

"Birth and Death"

02087

159

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

<p>1. PLACE OF BIRTH:</p> <p>County <u>Washington</u></p> <p>City or town <u>Hyattsville</u> (If outside city or town limits, write RURAL and give nearest town)</p> <p>Street address, hospital, or institution: <u>Washington County Hospital</u></p> <p>Length of mother's stay in County <u>1 year</u> (How many years, or months, or days. SPECIFY WHICH)</p>		<p>2. USUAL RESIDENCE OF MOTHER:</p> <p>State <u>Maryland</u></p> <p>County <u>Washington</u></p> <p>City or town <u>Laurel</u> (If outside city or town limits, write RURAL and give nearest town)</p> <p>Street No. _____ (If RURAL give LOCATION)</p>	
<p>3. Name of child <u>Baby Boy Anderson</u></p> <p>5. Sex <u>Male</u></p>		<p>4. Date of birth <u>Feb 21 1947</u> Hour <u>5:30 A</u> M.</p> <p>7. No. of weeks pregnancy <u>26</u></p>	
<p>FATHER OF CHILD</p> <p>8. Full name <u>Precious Howard Anderson</u></p> <p>9. Color <u>white</u></p> <p>10. Age at time of this birth <u>47</u> yrs.</p> <p>11. Usual occupation <u>P. Bliss + Sand Co.</u></p>		<p>MOTHER OF CHILD</p> <p>12. Full maiden name <u>Bessie Lee Jackson</u></p> <p>13. Color <u>white</u></p> <p>14. Age at time of this birth <u>36</u> yrs.</p> <p>15. Usual occupation <u>Housewife</u></p>	
<p>16. Other children born to mother (not including present child): (a) How many children of this mother are now living? <u>6</u> (b) How many other children were born alive but are now dead? <u>2</u> (c) How many other children were born dead? <u>2</u></p>			
<p>17. Did child die before labor? <u>No</u> During labor? <u>No</u></p> <p>18. Pregnancy, complications of <u>None</u></p>		<p>21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof. (a) Fetal causes <u>Prematurity</u> (b) Maternal causes <u>Premature Rupture of membranes</u></p>	
<p>19. Labor: (a) Complications of <u>Premature Rupture of membranes</u> (b) Induced? <u>No</u></p> <p>20. (a) Was there an operation for delivery? <u>No</u> (b) State all operations, if any <u>None</u> (Yes or No)</p>		<p>22. I certify to the birth of this child who was <u>born dead</u> on the date and hour above stated. Signature <u>Archie Robert Chen M.D.</u> (Specify if M. D., midwife, or other)</p>	
<p>(c) Did child die before operation? <u>No</u> During operation? _____</p>		<p>Address <u>Clear Spring End.</u></p>	
<p>23. (a) <u>Buried</u> (b) Date thereof <u>Feb 22 1947</u> (Burial, cremation or removal) (month) (day) (year)</p> <p>(c) Cemetery or crematory <u>Pine Hill Cemetery, Md.</u></p>		<p>25. (a) <u>Feb 22 1947</u> (b) <u>Black Powers</u> (Date rec'd by registrar) (Registrar)</p>	
<p>24. (a) Funeral director <u>Samuel - 1 Paulsboro</u> (b) Address <u>Laurel Maryland</u></p>		<p>26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me. Health Officer, per _____</p>	

\* See Instruction C on stub.

Child lived 12 hours, 30 minutes

V. S. A10

Also tab. as live birth

RECEIVED

FEB 25 1947

BUREAU V B.

1-58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

## CERTIFICATE OF DEATH

Dr. Welty 226  
02038

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 Days  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 64 1/2 West Franklin St.  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war... None

## 3. (a) FULL NAME

JOSEPH EDWARD BAXTER

## 3. (b) Social Security Number

220-05-6793

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower  
 6.(b) Name of husband or wife... Aranda Weller  
 7. Birth date of deceased (mo., day, yr.) October 9, 1868  
 6.(c) If alive, give age... years

8. AGE: Years 78 Months 4 Days 3 it less than one day  
 --- hrs. --- min.

9. Birthplace... Thurmont, Fredrick Co., Md.  
 (Town, county, and state)

10. Usual occupation... Carpenter

11. Industry or business... -

12. Name... Edward Baxter

13. Birthplace... Thurmont Md.

14. Maiden name... Barbara Rowe

15. Birthplace... Thurmont Md.

16. Informant... Mrs. Wilbur Brown

Address... Thurmont Md.

17. Burial... United Bretherned Cemetery  
 (Burial, cremation, or removal. Which?) Date thereof... 2/15/47  
 (month, (day) (year)

Cemetery or crematory... Thurmont, Maryland

Location... M. L. Creager & Sons

18. Funeral director... Thurmont Maryland

Address... Feb. 14, 1947

19. (Date rec'd by registrar) 1947 Charles Bowers  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... February 12 19. 47 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 27 19. 47 to Feb. 12 19. 47  
 and that I last saw him alive on Feb. 12 19. 47

Immediate cause of death... Generalized Peritonitis DURATION 2 weeks

Due to... Acute Appendicitis 2 weeks

Due to...

Other conditions... Arteriosclerosis General 20 years

(Include pregnancy within 3 months of death)

Major findings of operations... Generalized Peritonitis

Autopsy results... Generalized Peritonitis, Abdominal Abscess Date of op. Jan 31st 1947

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE... Sutton M. Welty, M.D. M. D. or other

Address... Hagerstown Maryland Date signed... 2-13-47

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FEB 17 1947  
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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County Washington  
 City or town Rural Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 Years  
 Hospital, institution, or street address where death occurred:  
Dual Highway  
 How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Dual Highway  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS JULIA MAE BREWER

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Renner Brewer  
 6. (c) If alive, give age 63 years  
 7. Birth date of deceased (mo., day, yr.) May 5, 1892  
 8. AGE: Years 54 Months 9 Days 4 If less than one day -- hrs. -- min.

9. Birthplace Benevola, Washington Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home  
 12. Name Jacob R. Reid  
 13. Birthplace Hagerstown Md.  
 14. Maiden name Helen M. Artz  
 15. Birthplace Fairplay Md.

18. Informant Renner Brewer  
 Address Hagerstown Md.

17. Burial Burial Date thereof 3/12/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Pauls Cemetery  
 Location Western Pike Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Feb. 11 19 47 Phaedra Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 19 47, at 1:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3 19 44, to Feb. 9 19 47  
 and that I last saw him alive on Feb. 4 19 47

Immediate cause of death Cerebral Hemorrhage DURATION 1 hr

Due to Hypertensive Crisis -  
vascular disease

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Sidney Hovesteen MD M. D. or other \_\_\_\_\_  
J. H. Bowers MD Address \_\_\_\_\_ Date signed 2/9/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 13 1947

BUREAU

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Wells

02040

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 Years  
 Hospital, institution, or street address where death occurred:  
107 North Foundry St.  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 107 North Foundry St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3.(a) FULL NAME

Charles H. Burns

## 3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Single6.(b) Name of husband or wife ---7. Birth date of deceased (mo., day, yr.) December 13 18848. AGE: Years Months Days It less than one day  
62 2 10 hrs. min.9. Birthplace Smithsburg Wash. Co. Md.  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business ----12. Name George W. Burns13. Birthplace Martinsburg W. Va.14. Maiden name Catherine Tracy15. Birthplace Wolfesville Md.16. Informant Mrs. Catherine BurnsAddress Hagerstown Md.17. Burial Date thereof 2/25/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Chestnut Bethel CemeteryLocation near Wolfesville Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb. 25. 47 Charles H. Burns  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1947 at about 1:10pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19and that I last saw him alive on 19Immediate cause of death PsychoticDue to generalized vasculararteriosclerosisDue to chr. glomerular nephritisOther conditions chr. myocarditisacute ventricular fibrillation  
(Include pregnancy within 3 months of death)Major findings of operations ---Date of op. ---Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury Injured at work?

23. SIGNATURE Dr. Robert T. Wells M. D. o ---Address Hagerstown, Md. Date signed Feb. 24. 47



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FEB 28 1947  
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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *92-d*

## CERTIFICATE OF DEATH

Reg. Dist. No. *02044 3020*

## 1. PLACE OF DEATH:

County *Washington*  
 City or town *Hagerstown*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *45 Years*  
 Hospital, institution, or street address where death occurred:  
*750 Spruce St.*  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Washington*  
 City or town *Hagerstown*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *750 Spruce St.*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

*Ella V. Cordell*

## 3. (b) Social Security Number

*None*

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*  
 6. (b) Name of husband or wife *George F. Cordell*  
 6. (c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) *March 7, 1882*  
 8. AGE: Years *64* Months *11* Days *8* If less than one day  
 hrs. min.

9. Birthplace *Franklin Co. Penna.*  
 (Town, county, and state)  
 10. Usual occupation *Home Duties*  
 11. Industry or business

FATHER 12. Name *Myers*  
 13. Birthplace *Penna.*  
 MOTHER 14. Maiden name *Unknown*  
 15. Birthplace *Penna.*

16. Informant *Mrs. Gladys White*  
 Address *1101 Brentwood Ave. Baltimore, Md*

17. *Burial* Date thereof *Feb. 18, 1947*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory *Rose Hill Cemetery*  
 Location *Hagerstown, Maryland*

18. Funeral director *Fred W. Kraiss*  
 Address *Hagerstown, Maryland*

19. *Feb. 19, 1947*  
 (Date rec'd by registrar) Registrar *Heath Jones*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 15, 1947* 19 *47* at *11* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb 15 1947* to *Feb 15 1947*  
 and that I last saw him alive on *Feb 15 1947*

Immediate cause of death *Cardio-Vascular Disease (?)*  
*(De-compensation)*  
*Chronic Endo Carditis*  
*Chronic Myo-Carditis* } *Indefinite*  
 Due to *rust*

Other conditions  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.

Antemortem results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE *V. H. Duncanson*  
 Address *Hagerstown Md* M. D. or other  
 Date signed *Feb 16 1947*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 21 1947  
BUREAU V.S.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02042

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
520 Washington Square  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 520 Washington Square  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War II

## 3. (a) FULL NAME

Hunter B. Cowden

## 3. (b) Social Security Number

212-14-7007

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
Male	White	Single	
6.(b) Name of husband or wife			
6.(c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>August 2, 1898</u>			
8. AGE:	Years	Months	Days
	48	6	3
It less than one day hrs. min.			

9. Birthplace Wilson District, Maryland  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John A. Cowden  
 13. Birthplace Cumberland, Maryland

MOTHER 14. Maiden name Anna M. Mentzer  
 15. Birthplace Wilson District, Maryland

16. Informant Ralph Cowden  
 Address Chambersburg, Pa.

17. Burial Date thereof 2-7-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Paul Cemetery  
 Location Western Pike

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. Feb. 6, 47 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/47 1947 at 3 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 1947 to Feb 5 1947  
 and that I last saw him alive on Feb 6 1947

Immediate cause of death	DURATION
<u>Pneumonia</u>	<u>1 day</u>
<u>Cardiac Degeneration</u>	<u>1 day</u>
Due to	
Due to	
Other conditions	
(Include pregnancy within 8 months of death)	

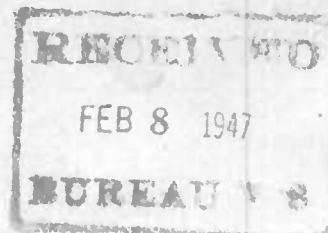
Major findings of operations Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Thos O. Hughes M. D. or other  
 Address Hagerstown Md Date signed 2/5/47



25-1

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County.....Washington  
 City or town.....Halfway  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....4 months  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....Md. County.....Washington  
 City or town.....Halfway  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....35 Coffman Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

CHARLES EDWARD CUNNINGHAM

## 3. (b) Social Security Number

4. Sex.....M 5. Color or race.....W 6.(a) Single, married, widowed, or divorced.....Widower

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....December 1, 1864

8. AGE: Years.....82 Months.....2 Days.....13 If less than one day..... hrs. .... min.

9. Birthplace.....Cearfoss, Maryland  
(Town, county, and state)10. Usual occupation.....Farmer

11. Industry or business.....

12. Name.....George C. Cunningham13. Birthplace.....No Record14. Maiden name.....Annie Cosey15. Birthplace.....No Record16. Informant.....Harry CunninghamAddress.....Milnor, Penna.17. Burial.....Burial Date thereof.....Feb. 16, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....St. PaulsLocation.....Western Pike, Wash. Co., Md.18. Funeral director.....Wm. A. TeeterAddress.....Greencastle, Penna.19. Feb. 15 1947 Registrar.....Chas. H. Buerd  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....February 14 1947 at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 20 1947 to Feb. 14 1947  
 and that I last saw him alive on February 10 1947

Immediate cause of death.....Senile arteriosclerotic nephrosclerosis  
 DURATION.....2

Due to.....

Due to.....

Other conditions.....None

(Include pregnancy within 3 months of death)

Major findings of operations.....No operationAutopsy results.....No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, on in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

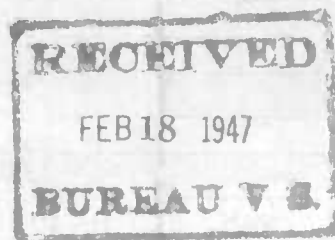
Means of injury..... Injured at work?

23. SIGNATURE.....La Bell M. D. or otherAddress.....Hagerstown Md. Date signed.....2/15/47

MARGIN RESERVED FOR BINDING

VS A15 -9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore 525 ✓

## CERTIFICATE OF DEATH

Dr. Yeager

206

02044

Reg. Diat. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 Days  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 4 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 113 S. Locust St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... None

## 3. (a) FULL NAME

JOSEPH VINCENT DAVIS

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mary Elizabeth  
 6. (c) If alive, give age 84 years  
 7. Birth date of deceased (mo., day, yr.) October 10, 1860

8. AGE: Years 86 Months 3 Days 26 If less than one day  
 ... hrs. ... min.

9. Birthplace St. James, Washington Co. Md.  
 (Town, county, and estate)

10. Usual occupation Wholesale Grocery Clerk

11. Industry or business Retired

FATHER 12. Name Jonathan Davis  
 13. Birthplace Fairplay Md.

MOTHER 14. Maiden name Mary Lookingland  
 15. Birthplace Germany

16. Informant Mrs. Mary E. Davis  
 Address Hagerstown Md.

17. Burial Date thereof 2/4/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Feb. 4. 19 46 Chas. H. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1947 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4, 1947, to Feb. 2, 1947, and that I last saw him alive on Feb. 1, 1947.

Immediate cause of death  
Adenocarcinoma of Bladder 730-587  
" " of Prostate 764-8860  
" " of Pancreas 730-4657  
due to Ch. Rodentia

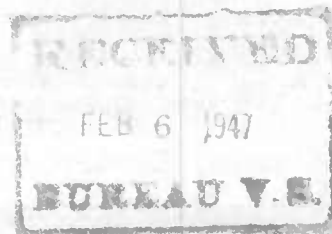
Due to " "  
 Due to " "  
 Other conditions " "

(Include pregnancy within 3 months of death)  
 Major findings of operations None  
 Date of op. None  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide X Date of X  
 Where did injury occur? X (City or town) X (County) X (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE W. Howard Yeager  
Hagerstown Md.  
 Address Date signed 2-3-47





1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63-2

## CERTIFICATE OF DEATH

Dr. Lusby

223

02045

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Years

Hospital, institution, or street address where death occurred:

2112 Virginia AveHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2112 Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

EDWARD RENCH DELLINGER

## 3. (b) Social Security Number

219-12-0354

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteMarried6.(b) Name of husband or wife Ida Rhodes6.(c) If alive, give age 69 years7. Birth date of deceased (mo., day, yr.) December 18 18768. AGE: Years Months Days If less than one day  
70 1 22 hrs. min.9. Birthplace Downsville Wash. Co. Md  
(Town, county, and state)10. Usual occupation Wood Worker11. Industry or business M.P. Moller Co.12. Name Andrew Dellinger13. Birthplace Downsville Md.14. Maiden name Susan Hoffeditz15. Birthplace Mercersburg Pa.16. Informant Mrs. Ida R. DellingerAddress Hagerstown Md.17. Burial Date thereof 2/15/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb. 13. 19 47 Charles H. Bowers

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

February 12 194720. DATE OF DEATH February 12 1947 at 1 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 Feb 19 47 to 12 Feb 19 47and that I last saw him alive on 12 Feb 19 47Immediate cause of death Cerebral Hemorrhage

DURATION

5 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

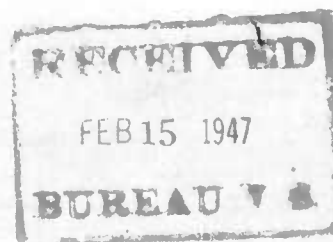
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. Lusby M. D. or otherAddress 2301 N. Potomac Date signed 13 Feb 47



1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
 County Hagerstown  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 74 years  
 Hospital, institution, or street address where death occurred: 340 N. Jonathan Street  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 340 N. Jonathan Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME Mary Nelsaw Dixon

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Henry Dixon  
 6. (c) If alive, give age  years  
 7. Birth date of deceased (mo., day, yr.) November 13, 1872

8. AGE: 74 Years 2 Months 22 Days  hrs.  min.

9. Birthplace Hagerstown, Wash. Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William E. Nelsaw

13. Birthplace Hagerstown, Md.

14. Maiden name Elizabeth Taylor

15. Birthplace Richmond, Va.

16. Informant Mrs. M. Petta Harris

Address 340 N. Jonathan Street

17. Burial Rose Hill Cemetery

(Burial, cremation, or removal. Which?) Date thereof 2/6/47  
 (month) (day) (year)

Cemetery or crematory Hagerstown, Md.

Location

18. Funeral director William H. Downey

Address 2917 Redlick St. Hagerstown

Feb. 6, 47 Charles Bowens

19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3/47 1947 at 109 W

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to 2/3/47  
 and that I last saw him alive on 1/31/47 1947

Immediate cause of death Acute dilatation of heart  
Decompensatory heart -

DURATION

2 yrs -

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE Charles Bowens

M. D. or other

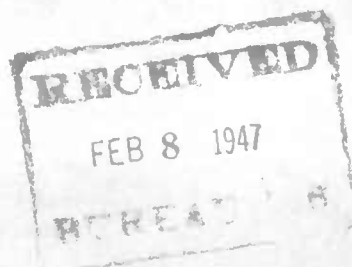
Address Hagerstown Md - Date signed 2/3/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Dr. Ralph Young

02047

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County Washington  
Hagerstown  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 Days  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 13 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Williamsport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 111 West Potomac St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

CHARLES FRANCIS DOUGHTY

## 3. (b) Social Security Number

219-05-2175

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Myrtle  
 6.(c) If alive, give age 65 years  
 7. Birth date of deceased (mo., day, yr.) November 24 1872  
 8. AGE: Years 74 Months 2 Days 10 If less than one day hrs. min.

9. Birthplace Newark Newark Essex Co New Jersey  
 (Town, county, and state)  
 10. Usual occupation Leather Worker  
 11. Industry or business W.D. Byron Tannery

MOTHER FATHER  
 12. Name No Record  
 13. Birthplace No Record  
 14. Maiden name No Record  
 15. Birthplace No Record

16. Informant Mrs. Myrtle Doughty  
 Address Williamsport Md.

17. Burial Date thereof 2/10/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Feb. 9 19 47 Charles Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1947 19 47 12.05 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him 1/25/47 on 2/8/47 19 47Immediate cause of death CrowleyObstruction

## DURATION

1 Day

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. F. YoungAddress Williamsport Md. Date signed 2/8/47

RECEIVED  
FEB 11 1947  
BUREAU

1-50



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

Reg. Dist. No. 3022

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 2 months  
 Hospital, institution, or street address where death occurred:  
121 John St.  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .... 121 John St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

ANNA MYRTLE BAKER ESHLEMAN

## 3. (b) Social Security Number

none

4. Sex..... F 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... Widow  
 6.(b) Name of husband or wife..... Daniel R.  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... July 2, 1870  
 8. AGE: Years..... 76 Months..... 7 Days..... 26 If less than one day..... hrs. .... min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 28 1947 at 10:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
15 March 1946 to 28 Feb 1947  
 and that I last saw her alive on 28 Feb 1947

Immediate cause of death..... Myocardial infarction + arteriosclerosis  
Coronary vascular disease  
 DURATION..... 10 yrs. +

Due to.....

Due to.....

Other conditions..... Yes

(Include pregnancy within 3 months of death)

Major findings of operations..... My

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. J. Lusby M. D. or otherAddress..... 2300 Plover Date signed..... 1 Mar 47

9. Birthplace..... Wingerton, Penna.  
 (Town, county, and state)  
 10. Usual occupation..... Housewife  
 11. Industry or business..... Own Home  
 12. Name..... D. H. Baker  
 13. Birthplace..... No Record  
 14. Maiden name..... Anna Weyant  
 15. Birthplace..... No Record  
 18. Informant..... Mrs. Ray Hawbaker  
 Address..... Greencastle, Penna.  
 Burial..... Date thereof..... March 3, 1947  
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)  
 Cemetery or crematory..... Beautiful View  
 Location..... State Line, Md.  
 18. Funeral director..... Jacob A. Tester  
 Address..... Greencastle, Penna.  
 19. Mar. 1, 47 Chas. H. Howard  
 (Date rec'd by registrar)..... Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 4 1947

BUREAU V 8

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

## CERTIFICATE OF DEATH

Reg. Dist. No. 02049 3020

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 night  
 Hospital, institution, or street address where death occurred:  
Washington Co. Hospital  
 How long in hospital or institution? 1 night

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hancock  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. East Main  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... World War II

## 3. (a) FULL NAME

John Hamilton Everetts

## 3. (b) Social Security Number

212-10-8530

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife —  
 6. (c) If alive, give age — years  
 7. Birth date of deceased (mo., day, yr.) Oct. 19, 1897  
 8. AGE: Years 49 Months 3 Days 16 If less than one day — hrs. — min.

9. Birthplace Hancock Wash. Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Driller at Sand Mine  
 11. Industry or business —

FATHER 12. Name James Hamilton Everetts  
 13. Birthplace Wash. Co. Md.  
 MOTHER 14. Maiden name Dorothy Houck  
 15. Birthplace Wash. Co. Md.

16. Informant James M. Everetts  
 Address E. Main St., Hancock, Md.  
 17. Burial Date thereof Feb. 7, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Riverview Cemetery  
 Location Hancock, Md.

18. Funeral director Charles R. Bast  
 Address Hancock, Md.

19. Feb. 4, 1947 Registrar Black Howard  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1947 at 5:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3, 1947 to Feb. 4, 1947  
 and that I last saw him alive on Feb. 3, 1947

Immediate cause of death Arterio-sclerotic heart disease DURATION 2 mos.

Due to —

Due to —

Other conditions Hypostatic pneumonia 1 wk.  
 (Include pregnancy within 3 months of death)

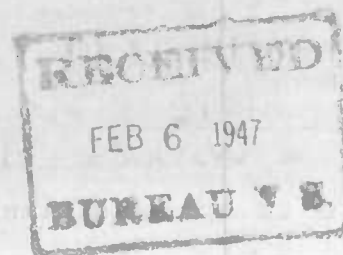
Major findings of operations — Date of op. —

Autopsy results —  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide — Date of —  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —  
 Means of injury — Injured at work? —

23. SIGNATURE R. L. Hanff, M.D. M. D. or other —  
 Address Hagerstown, Md. Date signed Feb. 4, 1947



1-50

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

Reg. Dist. No. 02050 3020

## 1. PLACE OF DEATH:

County Washington  
Hagerstown  
 City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 1 hour 30 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Washington  
Hagerstown  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 765 Spruce St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## 3. (a) FULL NAME

Unnamed Child of James Forcino

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

February 10, 1947

## 8. AGE:

Years

Months

Days

If less than one day

1

hrs.

30

min.

## 9. Birthplace

Hagerstown, Wash. Co., Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER

## 12. Name

James Forcino

## 13. Birthplace

Berekeley, W. Va.

MOTHER

## 14. Maiden name

Dorothy Fink

## 15. Birthplace

Williamsport, Md.

## 16. Informant

James Forcino

## Address

Hagerstown, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

2-12-47

(month) (day) (year)

## Cemetery or crematory

Rose Hill Cemetery

## Location

Hagerstown, Md.

## 18. Funeral director

Scott F. Minnich & Son

## Address

Hagerstown, Md.

## 19. (Date rec'd by registrar)

Feb. 12, 47

19

47Charles H. Bowers  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1947, at 8:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

DURATION

Atelectasis of new bornDue to premature (5wks premature  
wt 3lbs 13 oz.)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

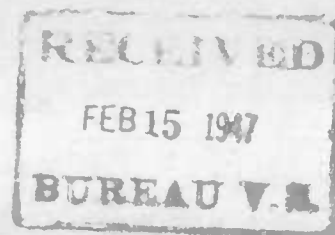
23. SIGNATURE

A. Robert Wells, M.D.  
 Address Hagerstown, Md. Date signed Feb. 10, 47

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-50

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 3452

## 1. PLACE OF DEATH:

County Washington  
 City or town Bonnsboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
St. Paul St.  
 How long in hospital or institution? at Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Bonnsboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. St. Paul St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Helen Ford

## 3. (b) Social Security Number

212-14-6330

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife Single 6. (c) If alive, give age \_\_\_\_\_ years7. Birth date of deceased (mo., day, yr.) January - 3, 18688. AGE: Years 79 Months 1 Days 2 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Bonnsboro Wash. Co. md.  
(Town, county, and state)10. Usual occupation Alteration Department11. Industry or business Fifty Bros. Dept StoreFATHER 12. Name Joshua Ford13. Birthplace Bonnsboro Wash. Co. md.MOTHER 14. Maiden name Mary Brink15. Birthplace Frederick Fred. Co. md.16. Informant Miss Mary FordAddress Bonnsboro md.17. Burial Date thereof Feb. 8 - 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bonnsboro CemeteryLocation Bonnsboro md.18. Funeral director Wm. J. Bast & SonAddress Bonnsboro md.19. Feb. 7. 19 47 John H. Bast  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 19 47 at 9 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5 19 47 to Feb. 5 19 47 and that I last saw her alive on Feb. 5 19 47

Immediate cause of death \_\_\_\_\_ DURATION

Chronic Myocarditis - 5 yrsDue to Senile Dementia 3 yrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. W. L. M. W. M. D. or otherAddress Bonnsboro Date signed 2/7/47



RECEIVED

FEB 10 1947

BUREAU

1-58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County.....Washington  
 City or town.....Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....69 years  
 Hospital, institution, or street address where death occurred:  
140 E. Franklin St.  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....Wash.  
 City or town.....Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....140 E. Franklin St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Robert C. Garlock

## 3.(b) Social Security Number

--

4. Sex.....male 5. Color or race.....white 6.(a) Single, married, widowed, or divorced.....widowed  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.).....July 19, 1877  
 8. AGE: Years.....69 Months.....6 Days.....28 If less than one day..... hrs. .... min.

9. Birthplace.....Hagerstown, Wash. Co., Md.  
 (Town, county, and state)

10. Usual occupation.....none

## 11. Industry or business

12. Name.....Harry Garlock  
 13. Birthplace.....Germany  
 14. Maiden name.....Sarah A. Mace  
 15. Birthplace.....Hagerstown, Md.

16. Informant.....Mrs. Emma Bender  
 Address.....Hagerstown, Md.

17. burial Date thereof.....2-19-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....Rose Hill Cemetery  
 Location.....Hagerstown, Md.

18. Funeral director.....Scott F. Minnich & Son  
 Address.....Hagerstown, Md.

19. Feb. 19, 1947  
 (Date rec'd by registrar) Registrar.....W. B. Bowers

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....Feb. 17, 1947.....6:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
2-15.....1947 to 2-17.....1947  
 and that I last saw him alive on 2-17.....1947

Immediate cause of death.....Cerebral Hemorrhage  
 DURATION.....2 days

Due to.....Cerebral Arteriosclerosis  
 DURATION.....5 years

Due to.....

Other conditions.....Hypertension - Arteriosclerosis  
Heart Disease - myocardial failure  
 (Include pregnancy within 3 months of death) DURATION.....2 years

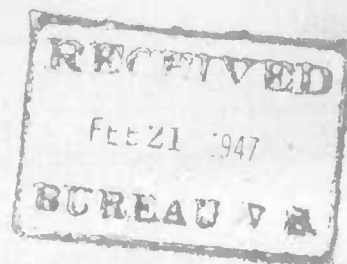
Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE.....Walter M. Welly, M.D.  
 M.D. or other.....  
 Address.....Hagerstown, Maryland Date signed.....2-18-47



1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

02053

2423

## 1. PLACE OF DEATH:

County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 YRS.

Hospital, institution, or street address where death occurred:  
WASHINGTON COUNTY HOSPITAL

How long in hospital or institution? 9 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 325 S. POTOMAC ST.  
 (If rural, give LOCATION)

2.(a) If veteran, name war NON-VET.

## 3. (a) FULL NAME

JOHN ROBERT GROUND

## 3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE MARRIED

6. (b) Name of husband or wife OLIVE BLANCHE PRICE6. (c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) OCTOBER 19, 1867

8. AGE: Years 79 Months 4 Days 2 If less than one day  
 hrs. min.

9. Birthplace BALTIMORE MARYLAND  
 (Town, county, and state)

10. Usual occupation RETIRED11. Industry or business RAIL ROAD12. Name JOHN GROUND13. Birthplace MARYLAND14. Maiden name EMMA SLICER15. Birthplace UNKNOWN16. Informant Joseph Ground (son)Address 871 Penna Ave17. BURIAL Date thereof OCT. 24, 1947

(Burial, cremation, or removal) (Which?) (month) (day) (year)

Cemetery or crematory Rose HillLocation Hagerstown, Md.18. Funeral director Woodford J. NormentAddress Hagerstown, Md.19. Feb. 22, 47 Chas. H. Howard  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb. 21, 47 at 6:02 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14, 47 to Feb. 21, 47and that I last saw him alive on Feb. 21, 47Immediate cause of death Dissected PericardiumLeft abundant Pericardium DURATION Feb. 12, 47Due to Cordis Vasculis Pericard. Feb. 19, 47acute suppurative pericarditis 24 hrsDue to Shock 48 hrsHypertrophy longissimus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Dissected Pericardiumabundant Pericardium Date of op. 2-18-47Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Howard M. D. or otherAddress Hagerstown, Md. Date signed Feb. 22, 1947

2033

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3050

## 1. PLACE OF DEATH:

County Washington  
 City or town San Mar  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 years  
 Hospital, institution, or street address where death occurred:  
Salvage Memorial Home  
 How long in hospital or institution? 22 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town San Mar  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Salvage Memorial Home  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

## 3. (b) Social Security Number

Mary Susan Hake

none

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Harry E. Hake  
 6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) January - 11 - 1860

8. AGE: Years 87 Months 1 Days 7 If less than one day hrs. min.

9. Birthplace Hagerstown Md.  
 (Town, county, and state)

10. Usual occupation none

## 11. Industry or business

12. Name James Eichelberger

13. Birthplace Hagerstown Wash. Co. Md.

14. Maiden name Mary S. Robinson

15. Birthplace Brownsville Wash. Co. Md.

16. Informant Maurice D. Slifer

Address Brownsville Md. R.2

17. Burial Date thereof February 21, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Middleton Cemetery

Location Middleton Penna.

18. Funeral director Wm J. Best & Sons

Address Brownsville Md.

19. Feb. 20 19 47 John D. Best  
 (Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 47 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 47 to Feb. 18 47 and that I last saw her alive on Feb. 17 47

Immediate cause of death Chronic Myocarditis DURATION 5 yrs

Due to Chronic Myocarditis

Due to Chronic Myocarditis

Other conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operation Chronic Myocarditis

Autopsy results Chronic Myocarditis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Chronic Myocarditis Date of Feb. 18 47

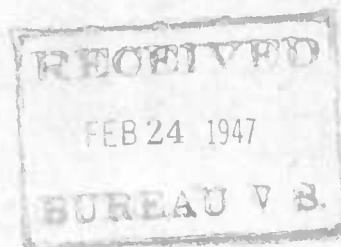
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Chronic Myocarditis

Means of injury Chronic Myocarditis Injured at work?

23. SIGNATURE G. W. Liden M.D. M. D. or other

Address Brownsville Date signed 2/19/47



1-50



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Prather

02055

243

Reg. Dist. No. 3026

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

132 S. Mulberry Ave.How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 132 S. Mulberry Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

HARRY LE FEVRE HAMMOND

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Ada Hammond6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) August 10, 1886

## 8. AGE:

Years

Months

Days

If less than one day

80614

.....hrs. ....min.

9. Birthplace Roxbury, Washington Co. Md.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Retired12. Name Washington Hammond13. Birthplace Roxbury Md.14. Maiden name Catherine15. Birthplace Williamsport Md.16. Informant Mrs. Ada HammondAddress Hagerstown Md.17. Burial Date thereof 2/27/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb. 25, 47 Blanch Flowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1947 at 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 21, 47 to Feb. 24, 47  
and that I last saw him 47 alive on Feb. 24, 1947

Immediate cause of death

Cerebral hemorrhage

DURATION

3 days

Due to

Interdementia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Prather

M. D.

Address Hagerstown Date signed 2/26/47

RECEIVED

FEB 28 1947

BUREAU V S

25-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

02056

1. PLACE OF DEATH: Washington  
 County Hagerstown  
 City or town (If outside city or town limits, write RURAL and give nearest town) 80 years  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 521 Jefferson St.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 Maryland Washington  
 State  
 Hagerstown  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 521 Jefferson  
 Street No. (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah A. Hartle

## 3. (b) Social Security Number

4. Sex Female  
 5. Color or race White  
 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife William B.  
 5.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 26 1866

8. AGE: Years 80 Months 11 Days 11 If less than one day  
 hrs. min.

9. Birthplace Hagerstown Wash. Md.  
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER 12. Name John C. Bowers

13. Birthplace Hagerstown Md.

MOTHER 14. Maiden name Mary E. Morgan

15. Birthplace Hagerstown Md.

16. Informant Daniel Bowers

Address Hagerstown Md.

17. Burial Date thereof 2-10-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. Feb 9 1947 [Signature] Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1947 11 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1947 to Feb 7 1947 and that I last saw him alive on Feb 7 1947

Immediate cause of death Cerebral hemorrhage DURATION 5 days

Due to Hypertension 10 yrs

Due to A few days 10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other

Hagerstown Md Date signed 2/8/47



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF STILLBIRTH**

159 02057  
 Reg. Dist. No. 3020

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

<p>1. PLACE OF BIRTH:</p> <p>County <u>Washington</u></p> <p>City or town <u>Hagerstown</u>  <small>(If outside city or town limits, write RURAL and give nearest town)</small></p> <p>Street address, hospital, or institution:  <u>Washington County Hospital</u></p> <p>Length of mother's stay in County <u>2 years</u>  <small>(How many years, or months, or days. SPECIFY WHICH)</small></p>	<p>2. USUAL RESIDENCE OF MOTHER:</p> <p>State <u>Maryland</u></p> <p>County <u>Washington</u></p> <p>City or town <u>Hagerstown</u>  <small>(If outside city or town limits, write RURAL and give nearest town)</small></p> <p>Street No. <u>66 West Side Ave.</u>  <small>(If RURAL give LOCATION)</small></p>
<p>3. Name of child <u>None</u></p> <p>5. Sex <u>Male</u>   6. Twin or triplet</p>	<p>4. Date of birth <u>Feb. 16 1947</u> Hour <u>10.25P</u> M.</p> <p>7. No. of weeks pregnancy <u>5 mos</u></p>
<p style="text-align: center;"><b>FATHER OF CHILD</b></p> <p>8. Full name <u>Vincent E. Heyworth</u></p> <p>9. Color <u>W</u> 10. Age at time of this birth <u>23</u> yrs.</p> <p>11. Usual occupation <u>Student</u></p>	<p style="text-align: center;"><b>MOTHER OF CHILD</b></p> <p>12. Full maiden name <u>Bridget Rogers</u></p> <p>13. Color <u>W</u> 14. Age at time of this birth yrs.</p> <p>15. Usual occupation <u>Home Duties</u></p>
<p>16. Other children born to mother (not including present child): (a) How many children of this mother are now living? <u>4</u>                  (b) How many other children were born alive but are now dead? <u>1</u> (c) How many other children were born dead? <u>0</u></p> <p>17. Did child die before labor? <u>No</u> During labor? <u>No</u></p> <p>18. Pregnancy, complications of</p> <p>19. Labor: (a) Complications of <u>None</u>                  (b) Induced?</p> <p>20. (a) Was there an operation for delivery? <u>No</u>  <small>(Yes or No)</small>                  (b) State all operations, if any                  (c) Did child die before operation?                  During operation?</p>	
<p>21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.                  (a) Fetal causes                  (b) Maternal causes <u>Not determined.</u></p> <p>22. I certify to the birth of this child who was born dead* on the date and hour above stated.</p> <p>Signature <u>H. D. Campbell M.D.</u>  <small>(Specify if M. D., midwife, or other)</small></p> <p>Address <u>145 W. Washington St.</u></p>	
<p>23. (a) <u>Burial</u> (b) Date thereof <u>Feb 18, 1947</u>  <small>(Burial, cremation or removal) (month) (day) (year)</small>                  (c) Cemetery or crematory <u>Rest Haven Cemetery</u></p> <p>24. (a) Funeral director <u>Fred W. Kraiss</u>                  (b) Address <u>Hagerstown, Maryland</u></p>	
<p>25. (a) <u>Feb 18, 1947</u> (b) <u>B. H. Rogers</u>  <small>(Date rec'd by registrar) (Registrar)</small></p> <p>26. (To be filled out if no physician was present at delivery.)                  The above certificate has been examined by me.                  Health Officer, per</p>	

\* See Instruction C on stub.

CHILD LIVED FOR 2 MINUTES

T  
 as taken  
 as birth  
 V. S. ALO

RECEIVED

FEB 20 1947

BUREAU V L

1-50

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Dr. Wells

02058

232

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

McDowell Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 39 Coffman Avenue  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

GEORGE H. HILL

## 3. (b) Social Security Number

705-10-5121

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Bertha Lewis Hill6. (c) If alive, give age 64 years7. Birth date of deceased (mo., day, yr.) March 28, 18798. AGE: Years 67 Months 11 Days 14 If less than one day  
..... hrs. .... min.9. Birthplace Frostburg, Allegany Co. Md.  
(Town, county, and state)10. Usual occupation Tie & Timber Solicitor11. Industry or business Western Maryland Railroad12. Name James Hill13. Birthplace Frostburg Md.14. Maiden name Rebecca Cessna15. Birthplace Bedford pa.16. Informant John Arthur HillAddress Hagerstown Md.17. Burial Date thereof 2/17/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb. 17, 47 Chas. H. Rovers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1947 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death..... DURATION

Due to.....

acute coronary occlusion

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operation NO

.....Date of op. ....

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of.....

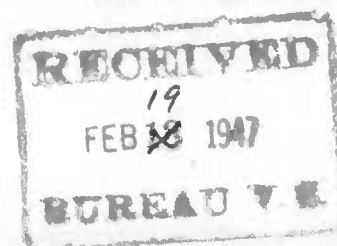
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells WASH. CO. MD.Address Hagerstown, Md. M. D. 2/17/47Date signed 2/17/47





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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 5 Days2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. Cedar Grove Farm  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS. NEVA GOENS HOWELL

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lee H.6. (c) If alive, give age 71 years7. Birth date of deceased (mo., day, yr.) December 27, 1882

## 8. AGE:

64

Years

1

Months

7

Days

If less than one day

--- hrs. --- min.8. Birthplace Charlestown, Jefferson Co. W.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Charles Goens13. Birthplace Charlestown W. Va.14. Maiden name Mary Roper15. Birthplace Charlestown W. Va.16. Informant Joseph R. HowellAddress Hagerstown Md.17. Burial Date thereof 2/9/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb. 8, 47 Charles R. Howard  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 19 47 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-2-47 19 47 to 2-6-47 19 47and that I last saw him alive on 2-6-47 19 47

Immediate cause of death

DURATION

Cerebral  
Hemorrhage  
6 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Ditto M. D. or otherAddress Hagerstown Md. Date signed 2/6/47

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FEB 11 1947  
BUREAU  
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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH- *Washington*County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *22 yrs.*

Hospital, institution or street address where death occurred:

*644 No Prospect St*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*MD* County.....*Washington*City or town.....*Hagerstown*  
(If outside city or town limits, write RURAL and give nearest town)Street No.....*644 N Prospect St*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

*NONE*

## 3. (a) FULL NAME

*Elenora Bachtell Isanogle*

## 3. (b) Social Security Number

*NONE*

## 4. Sex

*Female*

## 5. Color or race

*W*

## 6. (a) Single, married, widowed, or divorced

*Married*6. (b) Name of husband or wife.....*John W Isanogle*

## 7. Birth date of

deceased (mo., day, yr.)

*Nov 12 1875*

6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

*71**3**3*

..... hrs.

..... min.

## 9. Birthplace

*Hagerstown MD*  
(Town, county, and state)

## 10. Usual occupation

*Housewife*

## 11. Industry or business

*Own Home*

## FATHER

## 12. Name

*David Bachtell*

## 13. Birthplace

*Hagerstown MD*

## MOTHER

## 14. Maiden name

*Virginia Lidy*

## 15. Birthplace

*Hagerstown MD*

## 16. Informant

*Mr Lester Isanogle*

## Address

*Hagerstown MD*

## 17. (Burial, cremation, or removal). Which?

*Burial*

Date thereof.....

*Feb 18 1947*  
(month) (day) (year)

## Cemetery or crematory

*Rose Hill Cemetery*

## Location

*Hagerstown MD*

## 18. Funeral director

*Andrew R Hoffman*

## Address

*Hagerstown MD*

## 19. (Date rec'd by registrar)

*Feb 17 1947*

19

47

*Charles H. Brewer*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *February 15, 1947* at *9 A* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*September 30 1946* to *February 15 1947*

and that I last saw him alive on..... 19.....

## Immediate cause of death

*Congestive Heart Failure*

## DURATION

*3 years - duration*Due to *chronic cardio-vascular renal disease*

## Due to

Other conditions *arterial hypertension*

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

*Harold R. Palmage MD*

M. D. or other

Address *Waynesboro Pa* Date signed *Feb 15/47*

RECEIVED

<sup>19</sup>  
FEB 18 1947

BUREAU

1-50

Elenora Bachtell Isanogle

Mrs. Isanogle has been a Widow  
for quite a number of years,  
You should have Mr. Isanogle's  
death certificate in your files.  
He was an employee of  
M. P. Moller Organ Works,

Chas. H. Bowers  
Loc. Reg.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

02061

## CERTIFICATE OF DEATH

Reg. Dist. No. 2810

## 1. PLACE OF DEATH:

County Washington  
 City or town Williamsport R.F.D. #2  
 (if outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Williamsport Md.  
 (if outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (if rural, give LOCATION)

2.(a) If veteran, name war no

## 3.(a) FULL NAME

Albert Theodora Jackson

## 3.(b) Social Security Number

220 09 - 9028

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Edna Hose Jackson43

6.(c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

April 24 1888

## 8. AGE:

Years

59

Months

10

Days

29

If less than one day

hrs.

min.

## 9. Birthplace

Williamsport R.F.D. 2

(Town, county, and state)

## 10. Usual occupation

Laboer

## 11. Industry or business

Tannery Williamsport Md

## 12. Name

Jackson

## 13. Birthplace

dont Know

## 14. Maiden name

Amanda Teach

## 15. Birthplace

Williamsport Md R. F. D. #2

## 16. Informant

Mrs Edna Jackson

## Address

Williamsport Md R.F.D. #2

## 17. Burial

Feb 27 1947

(Burial, cremation, or removal, Which?)

Date thereof (month) (day) (year)

## Cemetery or crematory

Mennonite Cem.

## Location

Williamsport Md R. F. D. #2

## 18. Funeral director

Edith V. Leaf

## Address

7 & Church Williamsport Md.

## 19.

2/27 - 1947

(Date rec'd by registrar)

Mrs E. L. M. Elch

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

2/23/47

19

at

9P

M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/20/47

19

to

2/23/47

19

and that I last saw \_\_\_\_\_ alive on \_\_\_\_\_ 19

## Immediate cause of death

CerebralApoplexy

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Williamsport Md

M. D. or other

Date signed 2/27/47



RECEIVED  
MAR 1 1947  
BUREAU V. A.

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

CERTIFICATE OF DEATH

02062  
3020  
Reg. Diat. No.

1. PLACE OF DEATH: Washington  
County Hagerstown  
City or town (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 years  
Hospital, institution, or street address where death occurred: 22 Ruby Avenue  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 22 Ruby Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME Mary Louise Jackson 3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 13, 1913 6. (c) If alive, give age years

8. AGE: 34 Years 0 Months 1 Days hrs. min.

9. Birthplace Sheperdstown, W. Va  
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Walter S. Jackson

13. Birthplace Sharpsburg, Md.

14. Maiden name Lucinda Holmes

15. Birthplace Sheperdstown, W. Va

16. Informant Mrs. Lucinda Jackson  
Address 449 N. Jonathan Street

17. Burial Date thereof 2/18/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery  
Location Hagerstown, Md.

18. Funeral director William H. Ramsey  
Address 291 Frederick St Hagerstown

19. Feb. 18. 19 47 Black, Bowers  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about  
20. DATE OF DEATH February 14 19 47 at 7:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Aortic stenosis DURATION

Due to Myocardial failure 2 weeks

Due to

Other conditions

(Include pregnancy within 3 months of death)  
Major findings of operations None

Autopsy results None Date of op.  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAMINER  
Address Hagerstown, Md. Date signed 2/17/47

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 20 1947

BUREAU V. B.

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

02063

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 hours  
Hospital, institution, or street address where death occurred:

Washington County Hospital  
How long in hospital or institution? 36 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Washington

City or town Williamsport  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 S. Commerce  
(If rural, give LOCATION)

2.(a) If veteran, name war Private 3yrs service ic

## 3. (a) FULL NAME

George Franklin Jessop

## 3. (b) Social Security Number

215-09-7424

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Edna Thomas Jessop

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 11-1-89

8. AGE: Years 57 Months 3 Days 7 If less than one day  
.....hrs. ....min.

9. Birthplace Williamsport, Md.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Construction Work

12. Name Charles Jessop

13. Birthplace Williamsport, Md.

14. Maiden name Susan Watson

15. Birthplace West Virginia

16. Informant Edna Jessop

Address 15 S. Commerce St., Williamsport, Md.

17. Burial Date thereof 2-11-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverview Cem.

Location Williamsport, Md.

18. Funeral director Edith V. Leaf

Address Williamsport, Md.

19. Feb. 11, 1947 Registrar Chas. Bowers

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 19 47 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7 19 47 to Feb. 8 19 47

and that I last saw him alive on Feb. 8 19 47

Immediate cause of death Cerebral Hemorrhage DURATION 36 hrs

Due to unknown

Due to unknown

Other conditions unknown

(Include pregnancy within 3 months of death)

Major findings of operations unknown

Date of op. unknown

Autopsy results unknown

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide unknown Date of unknown

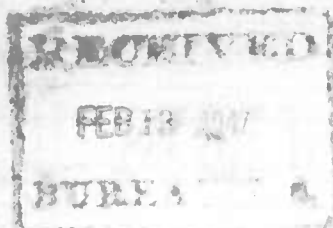
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) unknown

Means of injury unknown Injured at work? unknown

23. SIGNATURE Chas. Bowers M. D. or other

Address Williamsport, Md. Date signed Feb. 9, 47



1-50

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 78-d

## CERTIFICATE OF DEATH

Dr. Wells

02064

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Maugansville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 Years  
 Hospital, institution, or street address where death occurred:  
Main St.  
 How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Maugansville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Main St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

ROGER WILLIAM JOHNSTON

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife ---  
 7. Birth date of deceased (mo., day, yr.) August 9, 1902  
 6. (c) If alive, give age -- years  
 8. AGE: Years 44 Months 5 Days 22 It less than one day -- hrs. -- min.

9. Birthplace Maugansville, Washington Co. Md.  
 (Town, county, and state)

10. Usual occupation Electrician

11. Industry or business Own Employer

12. Name S. Walter Johnston

13. Birthplace Maugansville Md.

14. Maiden name Nettie Jones

15. Birthplace Maugansville Md.

16. Informant Mrs. Nettie J. Johnston

Address Maugansville Md.

17. Burial Date thereof 2/5/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb. 4, 47 Phas H. Bowers,  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 19 47, at 3 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 19 47, to Feb 3 19 47, and that I last saw him alive on Feb 2 19 47.

Immediate cause of death Coronary Thrombosis DURATION Sudden

Due to Chr. Myocarditis 5 yrs

Due to Cardiac Hypertrophy 5 yrs

Other conditions Bronchial Asthma 20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

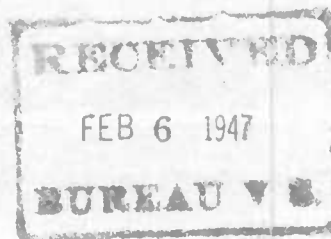
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury --- Injured at work? ---

23. SIGNATURE O. H. Brinkley M.D. M. D. or other

Address Hagerstown, Md. Date signed 2/4/47



1-50



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

34 High St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 34 High Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Emma E. Keedy

## 3.(b) Social Security Number

None

4. Sex.....  
 5. Color or race.....  
 6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband or wife..... Charles N. Keedy

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1869

8. AGE: Years..... Months..... Days..... If less than one day.....  
 77 4 28 hrs. min.

9. Birthplace.....  
 (Town, county, and state)

10. Usual occupation..... Home Duties

11. Industry or business.....

12. Name..... Charles F. Fleet

13. Birthplace..... Virginia

14. Maiden name..... Sarah P. Lowery

15. Birthplace..... Virginia

16. Informant..... Miss Ruth Keedy

Address 34 High St. Hagerstown, Md.

17. Burial.....  
 (Burial, cremation, or removal. Which?) Date thereof.....  
 (month) (day) (year)

Cemetery or crematory..... West Haven Cemetery

Location..... Hagerstown, Maryland

18. Funeral director..... Fred W. Kraiss

Address..... Hagerstown, Md.

19. Feb. 17, 1947.....  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 11, 1947..... 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 Nov - 1946 to Feb. 11, 1947  
 and that I last saw him alive on Feb. 9, 1947.

Immediate cause of death.....

DURATION

Cardiac Failure -  
 2 weeks -

Due to.....  
 Cardiac Decompensation -  
 2 yrs -

Due to.....

Other conditions.....  
 Arterio-sclerosis -  
 not known

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed 2/14/47

RECEIVED  
19  
FEB 18 1947  
BUREAU T R

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

02066

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH: Washington  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 years  
 Hospital, institution, or street address where death occurred:  
 Washington County Home  
 How long in hospital or institution? 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md. County..... Wash.  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
 Grover Leatherman

3. (b) Social Security Number  
 219-14-8746

4. Sex male  
 5. Color or race white  
 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1885

8. AGE: Years 61 Months 5 Days 4 hrs. min.

8. Birthplace Berekley Springs, Berekley Co., W. V.  
 (Town, county, and state)

10. Usual occupation laborer

11. Industry or business

12. Name Frederick Leatherman

13. Birthplace Maryland

14. Maiden name Mary Weller

15. Birthplace Maryland

16. Informant Fred Long

Address Hagerstown, Md

17. : Date thereof Feb 2, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Washington County Home

Location Hagerstown, Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown, Md.

19. Feb. 1, 1947 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1947 at 5:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/1/47 to 2/1/47 and that I last saw him alive on Jan 29, 1947

Immediate cause of death

Cerebral Hemorrhage

Due to Inter-sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest F. [Signature]

Address Hagerstown, Md. Date signed 2/1/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 4 1947

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

02067

Reg. Dist. No. 3050

### 1. PLACE OF DEATH:

County Washington  
City or town Bonabon  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 39 years  
Hospital, institution, or street address where death occurred Church St.  
How long in hospital or institution? at home

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Bonabon  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Church St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war no

### 3. (a) FULL NAME

Jessie M. Line

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife Single  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) March 19 1864  
8. AGE: Years 82 Months 10 Days 13 If less than one day hrs. min.

### MEDICAL CERTIFICATION

2D. DATE OF DEATH February 2 1947, at 6:30 P M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 1946, to Feb 2 1947, and that I last saw him alive on Feb 2 1947  
Immediate cause of death Rheumatic Myocarditis  
DURATION 37 days  
Due to   
Due to   
Other conditions   
(Include pregnancy within 3 months of death)

9. Birthplace Keedville Wash. Co. Md.  
(Town, county, and state)  
10. Usual occupation House Keeper  
11. Industry or business own home  
FATHER 12. Name Martin Line  
13. Birthplace Keedville Wash. Co. Md.  
MOTHER 14. Maiden name Sophia Thomas  
15. Birthplace Keedville Wash. Co. Md.  
16. Informant Mrs. Harvey Davis  
Address Bonabon Md.  
17. Burial Bonabon Cemetery Date thereof Feb 5 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Bonabon Md.  
Location Bonabon Md.  
18. Funeral director Wm J. Bart & Sons  
Address Bonabon Md.  
19. Feb 4 1947 John H. Bart  
(Date rec'd by registrar) Registrar

Major findings of operations  Date of op.   
Autopsy results   
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  Date of   
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury  Injured at work?  
23. SIGNATURE John H. Bart M. D. or other  
Address Bonabon, Md. Date signed 2/4/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 7 1947  
BUREAU

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

## CERTIFICATE OF DEATH

Dr. Lusby

02068

245

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 49 Years  
 Hospital, institution, or street address where death occurred:  
752 Spruce St.  
 How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 752 Spruce St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS LIZZIE AMELIA LONG

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Howard L. Long  
 6.(c) If alive, give age --- years  
 7. Birth date of deceased (mo., day, yr.) August 25, 1868  
 8. AGE: Years 78 Months 6 Days 0 If less than one day --- hrs. --- min.

9. Birthplace Benevola, Washington Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home  
 12. Name Basil Powell  
 13. Birthplace Hancock Md.  
 14. Maiden name Helen Maysillas  
 15. Birthplace Benevola Md.

16. Informant Mrs. Mary E. Seigman  
 Address Hagerstown Md.  
 17. Burial Burial Date thereof 2/27/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Dunkard Cemetery  
 Location Beaver Creek Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.  
 19. Feb. 26. 47 Chas H Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1947 at 8:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Feb 1946 to 25 Feb 1947  
 and that I last saw him alive on 23 Feb 1947

Immediate cause of death Septicemia secondary Cardiac vascular disease  
 DURATION 10-15 yrs

Due to Septicemia secondary Cardiac vascular disease  
 Due to Septicemia secondary Cardiac vascular disease  
 Other conditions Septicemia secondary Cardiac vascular disease

(Include pregnancy within 3 months of death)

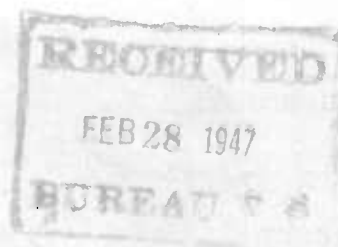
Major findings of operations Septicemia secondary Cardiac vascular disease  
 Date of op. Feb 25 1947

Autopsy results Septicemia secondary Cardiac vascular disease  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide --- Date of ---  
 Where did injury occur? --- (City or town) --- (County) --- (State)  
 Injured at home, farm, industry, public place (where?) ---  
 Means of injury --- Injured at work? ---

23. SIGNATURE J F Lusby M, D. or other ---  
 Address 230 N Potomac Date signed 26 Feb 47





1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B12)

## CERTIFICATE OF DEATH

Dr. Welty

02069

227

Reg. Dist. No. 3030

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 4 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 216 E. Antietam St.  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

FRANK CURVEY MAISACK

## 3. (b) Social Security Number

220-05-6924

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Amanda Maisack6. (c) If alive, give age 79 years7. Birth date of deceased (mo., day, yr.) January 31, 18718. AGE: Years Months Days If less than one day  
76 0 11 -- hrs. -- min.9. Birthplace Hagerstown Washington Co. Md.  
(Town, county, and state)10. Usual occupation Fireman11. Industry or business Hagerstown Fire Dept.12. Name Jacob Maisack13. Birthplace Germany14. Maiden name Louise Schevinger15. Birthplace Germany16. Informant Mrs. Amanda MaisackAddress Hagerstown Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/47  
(month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb. 15 47 Blas H. Brown  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1947 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to .....19.....

and that I last saw him alive on 2-14- 1947

Immediate cause of death

Uremia DURATION 4 weeksDue to Chronic Nephritis 4 yearsDue to Benign Prostatic Hypertrophy 3Other conditions Hypertension - Arteriosclerosis 4 yearsHeart Disease with Myocardial Insufficiency  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

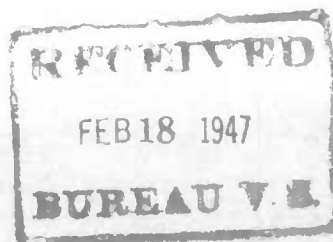
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Salmon M. Welty M.D.  
M. D. or otherAddress Hagerstown Maryland Date signed 2-14-47



1-58

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1864)

## CERTIFICATE OF DEATH

Reg. Dist. No. 3820

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? One year  
Hospital, institution, or street address where death occurred:  
807 Mulberry Ave.  
How long in hospital or institution? at Home.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 807 Mulberry Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war no

### 3. (a) FULL NAME

Margella Missouri Masty

### 3. (b) Social Security Number

- none.

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Clinton E. Masty

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February - 23 - 1859

8. AGE: Years 87 Months 11 Days 21 If less than one day hrs. min.

9. Birthplace near Myerstown Fred. Co. Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business own Home.

12. Name Lawson Haupt

13. Birthplace Fred. Co. Md.

14. Maiden name Mary Detrow

15. Birthplace Fred. Co. Md.

16. Informant Mrs. J. R. Ray Black

Address 807 Mulberry Ave. Hagerstown Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Feb. 17, 1947  
(month) (day) (year)

Cemetery or crematory Bonsibus Cemetery

Location Bonsibus Md.

18. Funeral director Wm. J. Best & Sons

Address Bonsibus Md.

19. (Date rec'd by registrar) Feb. 15, 47 Registrar Chaff Bowers

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1947 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Fractured humerus (closed) 7 weeks

Due to Coronary occlusion 14 days

Due to Accidental fall

Other conditions Cut for

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of December 27, 1946

Where did injury occur? Hagerstown Washington Maryland  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury Fall Injured at work?

23. SIGNATURE J. Robert Wells M.D. M. D. attest

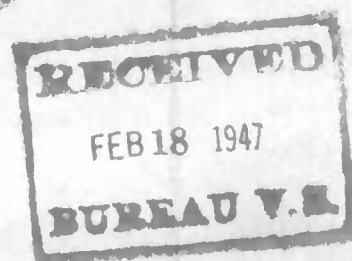
Address Hagerstown, Md. Date signed 2/15/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-50

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02070

3010

## 1. PLACE OF DEATH:

County Washington  
 City or town Williamsport R.F.D. #1  
 (If outside city or town limits, write R.F.D. and give nearest town)  
 How long in above place of death? 6yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Williamsport R.F.D. #1  
 (If outside city or town limits, write R.F.D. and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war no

## 3. (a) FULL NAME

Walter Thomas Mason, WALTER Thomas

## 3. (b) Social Security Number

220 09 7541

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mary Carbaugh Mason  
 6. (c) If alive, give age 38 years  
 7. Birth date of deceased (mo., day, yr.) Oct 29 1877  
 8. AGE: Years 69 Months 3 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Big Pool Md  
 (Town, county, and state)  
Conductor R.R.  
 10. Usual occupation  
 11. Industry or business Train  
 12. Name Jerry Mason  
 13. Birthplace Md  
 14. Maiden name Sera Mason  
 15. Birthplace Md

16. Informant Mary C. Mason  
 Address Williamsport R.F.D. #1  
 17. Burial Burial Date thereof Feb. 17 47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cem  
 Location Hagerstown Md.

18. Funeral director Edith V. Leaf  
 Address Williamsport Md

19. Feb 17 47 E Lee McElroy  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1947 19\_\_\_\_, at 8 P. M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/12/47 19\_\_\_\_ to 2/12/47 19\_\_\_\_  
 and that I last saw him alive on 2/12/47 19\_\_\_\_  
 Immediate cause of death Cerebral Hemorrhage  
 DURATION 2 yrs.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

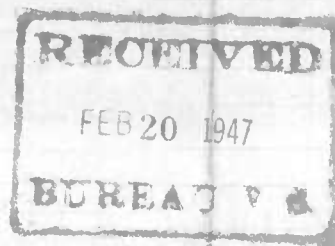
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE A. F. Young M. D. or other \_\_\_\_\_  
 Address Williamsport Md Date signed 2/17/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-50



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

## CERTIFICATE OF DEATH

02071

Reg. Dist. No. 3024

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 87 years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution?..... 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Wash.  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... cor. Antietam & Summit  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Norris Byers Meredith

## 3. (b) Social Security Number

--

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed  
 6.(b) Name of husband or wife..... Mollie Bikle Meredith  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... Aug. 20, 1859  
 8. AGE: Years..... 87 Months..... 5 Days..... 16 It less than one day..... hrs. .... min.

9. Birthplace..... Hagerstown, Wash. Co., Md.  
 (Town, county, and state)

10. Usual occupation..... retired

11. Industry or business.....

12. Name..... Unknown

13. Birthplace..... "

14. Maiden name..... Unknown

15. Birthplace..... "

16. Informant..... Frank Leiter

Address..... Hagerstown, Md.

17. burial Date thereof..... 2-7-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown, Md.

18. Funeral director..... Scott F. Minnich & Son

Address..... Hagerstown, Md.

19. Feb. 7, 1947 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 6, 1947 at 6:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him..... alive on.....19.....

Immediate cause of death.....

DURATION

Third Degree Burn to the

Due to..... of chest and

abdomen

Due to..... Trauma and

hypostatic pneumonia

Other conditions.....

Generalized vascular

arterial sclerosis

Major findings of operations.....

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: accident Date of..... Feb. 4, 1947

Accident, suicide, or homicide.....

Where did injury occur?..... Hagerstown, Wash. Co., Md.

Injured at home, farm, industry, etc., place where..... Rogers Hotel

Means of injury..... falling on floor Injured at work?..... no

23. SIGNATURE..... R. H. Miller WASH. CO., MD.

Address..... Hagerstown, Md. Date signed..... 2/7/47

RECEIVED

FEB 10 1947

B T V A

1-50

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Prather

Reg. Dist. No. 02072  
302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 years  
 Hospital, institution, or street address where death occurred:  
337 West Side Avenue  
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 337 West Side Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

FLORENCE VIRGINIA MILLER.

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Jacob Truman  
 6. (c) If alive, give age 78 years  
 7. Birth date of deceased (mo., day, yr.) November 15, 1870  
 8. AGE: Years 76 Months 2 Days 30 If less than one day -- hrs. -- min.

9. Birthplace Welsh Run, Franklin Co. Pa.  
 (Town, county, and state)  
 10. Usual occupation House Wife  
 11. Industry or business Own Home  
 FATHER 12. Name John Miller  
 13. Birthplace Welsh Run Pa.  
 MOTHER 14. Maiden name Annie Miller  
 15. Birthplace Welsh Run Pa.

16. Informant Jacob Truman Miller  
 Address Hagerstown Md.  
 17. Burial Date thereof 2/12/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Broadfording Cemetery  
 Location Broadfording Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.  
 19. Feb. 11, 47 Health Officers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8, 1947 to Feb. 9, 1947  
 and that I last saw him alive on Feb. 8, 1947

Immediate cause of death Chronic Myocarditis DURATION 25 yrs

Due to Hypertension 10 yrs.

Other conditions None  
 (Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide None Date of None  
 Where did injury occur? (City or town) (County) (State)

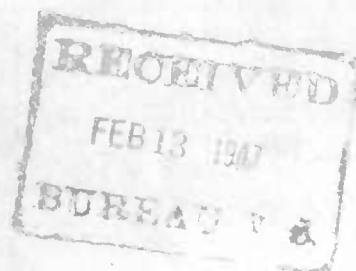
Injured at home, farm, industry, public place (where?) None  
 Means of injury None Injured at work? None

23. SIGNATURE B. Prather M. D. or other None  
 Address Hagerstown Md. Date signed 2.10.47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.



1-50

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 02073  
3020

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 53 years  
 Hospital, institution, or street address where death occurred:  
 Antietam Heights  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md. County..... Wash.  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Antietam Heights, RD#1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... World War I

## 3. (a) FULL NAME

Paul Leon Moser

## 3. (b) Social Security Number

214-09-7464

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mary A. Osborne Moser  
 6. (c) If alive, give age 52 years  
 7. Birth date of deceased (mo., day, yr.) January 22, 1894  
 8. AGE: Years 53 Months - Days 23 If less than one day hrs. min.

9. Birthplace Myersville, Fred. Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Machinist  
 11. Industry or business Fairchild Aircraft  
 12. Name Elmer Moser  
 13. Birthplace Myersville, Md.  
 14. Maiden name Temma Poffenberger  
 15. Birthplace Myersville, Md.

16. Informant Mrs. Mary Moser  
 Address Hagerstown, Md.

17. burial Date thereof 2-18-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown, Md.

18. Funeral director Scott F. Minnich & Son  
 Address Hagerstown, Md.

19. Feb. 18 1947 Chas. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1947 at 3:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/15/47 19 to 2/15/47 19  
 and that I last saw him alive on 19

Immediate cause of death Coronary Occlusion 10 min

Due to

Due to

Other condition Systemic Heart Disease 18 min  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE [Signature] M. D. or other

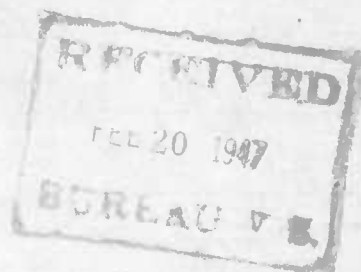
Address [Signature] Date signed 2/17/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-50.

*Transmitted*

## STATE OF MARYLAND—CERTIFICATE OF DEATH

02074

## 1. PLACE OF DEATH

County WashingtonVillage or City Sandy HookRegistration Dist. No. 3071

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 12 yrs. 0 mos. 0 ds. How long in U.S. if of foreign birth? 0 yrs. 0 mos. 0 ds.2. FULL NAME Josephene Molessa MyersIf U. S. Veteran, specify WAR None

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)Widowed

5a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofWilliam Myers6. DATE OF BIRTH (month, day, and year) Sept. 3, 1855

7. AGE

Years

Months

Days

If LESS than  
1 day, ..... hrs.  
or ..... min.91614

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.Housewife9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.Own Home10. Date deceased last worked at  
this occupation (month and  
year) 193511. Total time (years)  
spent in this  
occupation 65 yrs.

12. BIRTHPLACE (city or town)

(State or country)

Sharpsburg  
Maryland

FATHER

13. NAME

Ezra Reynolds

14. BIRTHPLACE (city or town)

(State or country)

Maryland

MOTHER

15. MAIDEN NAME

Margaret Mose

16. BIRTHPLACE (city or town)

(State or country)

Sharpsburg  
Maryland17. INFORMANT Mrs. Edith Payne, Box 150(Address) R.F.D., Knoxville, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Samples Manor Date 2/20, 19 47

19. UNOERTAKER

(Address)

Melvin T. Strider  
Charles Town, W. Va.

20. FILED

Feb. 19, 1947 Cornelius H. Beale  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

February 17, 1947  
(Month) (Day) (Year)

22.

I HEREBY CERTIFY, That I attended deceased from

47 Feb., 1947, to 17 Feb., 1947I last saw her alive on 17 Feb., 1947; death is saidto have occurred on the date stated above, at 0730 Pm.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Seni. CityDate of onset  
1946

Other Contributory Causes of Importance:

Carcinoma of large Bowel ?

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INOUSTRY, in HOME, or in PUBLIC PLACE

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed)

(Address)

R. Richard H. Saunders M. D.Baltimore, Md.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

*Arteriosclerosis*

*1915*

*Chronic interstitial nephritis*

*1921*

*Cerebral hemorrhage*

*July 5, 1927*

Other contributory causes of importance:

*Gallstones*

*May 1, 1923*

## Example II

The principal cause of death and related causes of importance were as follows:

*Attack of epilepsy*

*1 week ago*

*Run over by street car*

*1 week ago*

*Peritonitis*

*3 days ago*

Other contributory causes of importance:

*Gastroenteritis*

*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

2-3070 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

## CERTIFICATE OF DEATH

Dr. Hornbaker

02075

241

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death 29 Years  
 Hospital, institution, or street address where death occurred:  
711 Chestnut St.  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 711 Chestnut St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

FRANK WILBERT NIELD

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Margaret  
 6.(c) If alive, give age 52 years  
 7. Birth date of deceased (mo., day, yr.) July 21 1892  
 8. AGE: Years 54 Months 6 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maugansville Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Shoe Repair Man  
 11. Industry or business Own Business  
 12. Name William Nield  
 13. Birthplace Rohrersville Md.  
 14. Maiden name Ella E. McNamee  
 15. Birthplace Hagerstown Md.

16. Informant Mrs. Margaret Nield  
 Address Hagerstown Md.  
 17. Burial Date thereof 3/20/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Salem Reformed Cemetery  
 Location near Cearfoss Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Feb. 20, 1947 Clark Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH February 18 1947 19\_\_\_\_ at 6 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
5-9 1945 to 2-18 1947  
 and that I last saw him alive on 2-18 1947

Immediate cause of death Constrictive Heart Failure DURATION 21 months

Due to Hypertension Cardiovascular Dis. Unknown

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John Hornbaker M.D. M. D. or other

154 W. Washington St. Address Hagerstown Md. Date signed 2-19-47

RECEIVED

FEB 24 1947

BUREAU V S.

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

02076

Reg. Dist. No. 3820

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 29 years  
 Hospital, institution, or street address where death occurred:  
320 N. Prospect Street  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 320 N. Prospect St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3.(a) FULL NAME

John M. O' Connor

## 3.(b) Social Security Number

220-05-6495

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Lillian R. O' Connor  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) August 25, 1869  
 8. AGE: 77 Years 5 Months 10 Days If less than one day  
 ..... hrs. .... min.

9. Birthplace Thurmont- Fredk. Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Gas Co. Employee  
 11. Industry or business .....

MOTHER FATHER  
 12. Name Michael O' Connor  
 13. Birthplace Ireland  
 14. Maiden name Ellen Cole  
 15. Birthplace Ireland

16. Informant Charles M. O' Connor  
 Address 320 N. Prospect St., Hagerstown,

17. Burial Date thereof Feb. 7, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Md.

19. Feb. 7, 47 Registrar Philip Powers  
 (Date rec'd by registrar) .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1947 19....., at 7:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 4 19..... to Feb. 4 19.....  
 and that I last saw him/her alive on Feb. 4 19.....

Immediate cause of death  
Cerebral Hemorrhage  
Arteriosclerosis of the brain  
Coronary Arteriosclerosis  
 Due to.....

DURATION  
3 wks.  
1 yr.  
1 yr.

Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
MC

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury..... Injured at work? .....

23. SIGNATURE Philip Powers M. D. or other  
 Address 159 W. Washington St. Date signed 2/5/47

RECEIVED

FEB 10 1947

BUREAU V A

1-58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-7)

## CERTIFICATE OF DEATH

Reg.-Dist. No. 3020

<b>1. PLACE OF DEATH:</b> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>50 years</u> Hospital, institution, or street address where death occurred: <u>Washington County Hospital</u> How long in hospital or institution? <u>2 days</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>26 High St.</u> (If rural, give LOCATION) <u>World War I</u> 2. (a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Richard M. Palmer</u>				<b>3. (b) Social Security Number</b> <u>214-09-7257</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Divorced</u>		<b>MEDICAL CERTIFICATION</b>	
<b>6. (b) Name of husband or wife</b> <u>Ida Palmer</u>				<b>20. DATE OF DEATH</b> <u>February 7</u> 19 <u>47</u> at <u>5:19 a</u> M			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>May 16, 1895</u>				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Feb 3</u> 19 <u>47</u> to <u>28 2</u> 19 <u>47</u> and that I last saw him alive on <u>28 7</u> 19 <u>47</u>			
<b>8. AGE:</b> Years <u>50</u> Months <u>8</u> Days <u>21</u> If less than one day _____ hrs. _____ min.		<b>6. (c) If alive, give age</b> _____ years		<b>Immediate cause of death</b> <u>Cerebral hemorrhage</u> <u>(spontaneous subarachnoid)</u>		<b>DURATION</b> <u>7 da</u>	
<b>9. Birthplace</b> <u>Near Smithsburg Wash. Md.</u> (Town, county, and state)				<b>Due to</b> _____			
<b>10. Usual occupation</b> <u>Laborer</u>				<b>Due to</b> _____			
<b>11. Industry or business</b> <u>Victor Cushwa &amp; Son</u>				<b>Other condition</b> <u>Bronchitis pneumonia</u>			
<b>12. Name</b> <u>Fenton L. Palmer</u>				(Include pregnancy within 3 months of death)			
<b>13. Birthplace</b> <u>Unknown</u>				<b>Major findings of operations</b> _____			
<b>14. Maiden name</b> <u>Jennie</u>				<b>Date of op.</b> _____			
<b>15. Birthplace</b> <u>Unknown</u>				<b>Autopsy results</b> <u>Cerebral hemorrhage</u>			
<b>16. Informant</b> <u>Mrs. Belva G. Derr</u> Address <u>Hagerstown Md.</u>				<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>17. Burial</b> (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>2-12-47</u> (month) (day) (year) Cemetery or crematory <u>Antietam Cemetery</u> Location <u>Sharpsburg Md.</u> <u>Scott F. Minnich &amp; Son</u>				<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____			
<b>18. Funeral director</b> <u>Hagerstown Md.</u> Address _____				<b>23. SIGNATURE</b> <u>B. Fisher</u> M. D. _____ Address <u>Hagerstown</u> Date signed <u>2/8/47</u>			
<b>19. (Date rec'd by registrar)</b> <u>Feb 9 46</u>				<b>Registrar</b> <u>Chas. Bowers</u>			

RECEIVED  
FEB 11 1947  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County ~~Washington~~ HagerstownCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 49 years

Hospital, institution, or street address where death occurred:

210 Frederick St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland WashingtonCounty HagerstownCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 210 Frederick St.(If rural, give LOCATION)  
-----

2.(a) If veteran, name war

## 3.(a) FULL NAME

Camilla R. Pentz

## 3.(b) Social Security Number

-----

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 8.(b) Name of husband or wife

Russell I. Pentz

## 7. Birth date of deceased (mo., day, yr.)

May 22, 18736.(c) If alive, give age 73 years

## 8. AGE:

Years

73

Months

9

Days

3

If less than one day

hrs.

min.

## 9. Birthplace

Dillsburg York Pa.

(Town, county, and state)

## 10. Usual occupation

House Wife

## 11. Industry or business

Own HomeFATHER  
MOTHER

## 12. Name

Jacob Schultz

## 13. Birthplace

Big Springs Pa.

## 14. Maiden name

Lillian Keefauver

## 15. Birthplace

Allen Pa.

## 16. Informant

Russell I. Pentz

## Address

Hagerstown Md.

## 17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Rest Haven Cemetery

## Location

Hagerstown Md.

## 18. Funeral director

Scott F. Minnich & Son

## Address

Hagerstown Md.

## 19.

(Date rec'd by registrar)

19.

Feb. 28, 47

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1947 at 9 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 4, 1947 to Feb. 25, 1947  
and that I last saw him alive on February 25, 1947

Immediate cause of death

Chronic myocarditis

## DURATION

2

Due to

Due to

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

In operation

Date of op.

Autopsy results

In autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Ra Bee

M. D. or other

Address

Hagerstown Md.

Date signed

2/28/47

RECEIVED

MAR 3 1947

BUREAU V.B.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of  
age is shown on  
G 108 2/17/47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

## CERTIFICATE OF DEATH

Dr. Poole

02079

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Weeks

Hospital, institution, or street address where death occurred:

Washington County HomeHow long in hospital or institution? 3 Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. W. Washington St.  
(If rural, give LOCATION)2. (a) If veteran, name war None

## 3. (a) FULL NAME

HERBERT LAWSON POFFENBERGER

## 3. (b) Social Security Number

214-09-5453

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Ida Poffenberger6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) August 23, 1872

## 8. AGE:

Years

Months

Days

If less than one day

7211513-- hrs.-- min.9. Birthplace Locust Grove, Washington Co. Md.  
(Town, county, and state)10. Usual occupation Sole Cutter11. Industry or business Hagerstown Shoe & Legging Co.12. Name Jacob Poffenberger13. Birthplace Locust Grove Md.14. Maiden name Mary Ellen Price15. Birthplace Locust Grove Md.16. Informant Mrs. Thelma HershbergerAddress Hagerstown Md.17. Burial Date thereof 2/10/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb. 8, 47 Chas. H. Flowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1947 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1st 1947 to Feb. 8 1947  
and that I last saw him alive on Feb. 7 1947

Immediate cause of death

Chronic InterstitialDue to myocardialDue to arteriosclerosisOther conditions Myocardial Stenosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest H. Poole M. D. or otherAddress Hagerstown Md. Date signed 2/18/47

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FEB 14 1947  
BUREAU V A

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N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH 02080

## 1. PLACE OF DEATH

County WashingtonVillage or City SharpsburgRegistration Dist. No. 3000No. R. F. D. #1.St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred        yrs.        mos.        ds. How long in U.S. if of foreign birth?        yrs.        mos.        ds.2. FULL NAME Charles Franklin Ripple(a) Residence: No. Boonsboro R. F. D. St.        Ward.       

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5e. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Lulu Ripple</u>		
6. DATE OF BIRTH (month, day, and year) <u>April 17, 1874</u>		
7. AGE Years <u>72</u>	Months <u>10</u>	Days <u>4</u>
If LESS than 1 day, <u>      </u> hrs. <u>      </u> min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>Retired</u>	
	10. Date deceased last worked at this occupation (month and year) <u>      </u>	
		11. Total time (years) spent in this occupation <u>      </u>

12. BIRTHPLACE (city or town, State or country) Marlow Berkely Co. W. Va.FATHER 13. NAME John Ripple  
14. BIRTHPLACE (city or town, State or country) Marlowe West VirginiaMOTHER 15. MAIDEN NAME Louise Ridenour  
16. BIRTHPLACE (city or town, State or country) Marlowe West Virginia17. INFORMANT Mrs. Gladys Isanogle  
(Address) Hagerstown Md.18. BURIAL, CREMATION, OR REMOVAL  
Place Near Tilghmanton Date 2/23, 19 4719. UNDERTAKER Andrew K. Coffman  
(Address) Hagerstown Md.20. FILED Feb. 22, 19 47 E. J. Boyer  
Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Feb. 21, 1947.

(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1947, to Feb. 21, 1947.I last saw him alive on Feb. 18, 1947; death is said to have occurred on the date stated above, at 8 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cerebral arteriosclerosis  
Cerebral thrombosis

Date of onset

?  
4 week

Other Contributory Causes of importance:

Chronic nephritis  
Uremia?  
1 weekName of operation        Date of         
What test confirmed diagnosis?        Was there an autopsy?       

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?        Date of injury       , 19       Where did injury occur?         
(Specify city or town, county and State)  
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.Manner of injury       Nature of injury       24. Was disease or injury in any way related to occupation of deceased? noIf so, specify       (Signed) Walter K. Shady M. D.  
(Address) Sharpsburg, Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 754

## CERTIFICATE OF DEATH

Reg. Dist. No. 3050

## 1. PLACE OF DEATH:

County... Washington  
 City or town... San Juan  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 mo.  
 Hospital, institution, or street address where death occurred:  
Fahmy Memorial Home  
 How long in hospital or institution... 6 mo.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... W. Va. County... Berkely Co.  
 City or town... North Martinsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... no ✓

## 3. (a) FULL NAME

Franklin H. Robbins

## 3. (b) Social Security Number

none

4. Sex... Male 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Widowed  
 6. (b) Name of husband or wife... Hattie Naylor  
 7. Birth date of deceased (mo., day, yr.)... March - 4 - 1867  
 8. AGE: Years... 79 Months... 11 Days... 6 It less than one day... \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace... Berkely Co. W. Va.  
 (Town, county, and state)

10. Usual occupation... Retired merchant

## 11. Industry or business

12. Name... Allenis Robbins  
 13. Birthplace... Berkely Co. W. Va.  
 14. Maiden name... no Record  
 15. Birthplace... "

16. Informant... Miss Catherine Maynor  
 Address... Brownsville Md.

17. Burial Date thereof... Feb. 13, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Hedgesville Cemetery  
 Location... Hedgesville W. Va.

18. Funeral director... Howard K. Brown  
 Address... Martinsburg W. Va.

19. Feb. - 12 - 1947 John H. Best  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb. 10 19 47 at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Feb 8 19 47 to Feb. 10 19 47  
 and that I last saw him alive on Feb. 10 19 47

Immediate cause of death...

Chronic Myocarditis  
Uremia

DURATION

5 yrs2 yrs

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ....

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of... \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

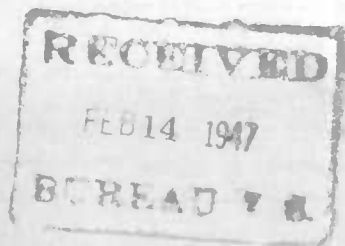
Means of injury

Injured at work?

23. SIGNATURE... G. W. Pelton M.D.  
 M. D. or other

Address... Brownsville Date signed... 2/11/47





1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7467

## CERTIFICATE OF DEATH

Dr. Lusby

02082

224

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 Weeks  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residences of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 630 Guilford Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... None

## 3. (a) FULL NAME

MRS. ALICE VIOLA ROOF

3. (b) Social Security Number  
None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife... Ellis T. Roof  
 6. (c) If alive, give age... 64 years  
 7. Birth date of deceased (mo., day, yr.) June 27, 1884  
 8. AGE: Years 62 Months 7 Days 13 If less than one day  
 -- hrs. -- min.

8. Birthplace Maugansville, Washington Co. Md.  
 (Town, county, and state)  
 10. Usual occupation House wife  
 11. Industry or business Own Home  
 12. Name Franklin Ruth  
 13. Birthplace Maugansville Md.  
 14. Maiden name Fianna Hunsberger  
 15. Birthplace Ephrata Pa.

16. Informant Ellis T. Roof  
 Address Hagerstown Md.  
 17. Burial Date thereof 2/15/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.  
 19. Feb. 13, 47 (Date rec'd by registrar) Registrar Charles H. Brown

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1947 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Feb 1947 to 12 Feb 1947  
 and that I last saw him alive on 12 Feb 1947

Immediate cause of death Coronary occlusion DURATION 2 weeks

Due to  
 Due to  
 Other conditions

(Include pregnancy within 3 months of death)

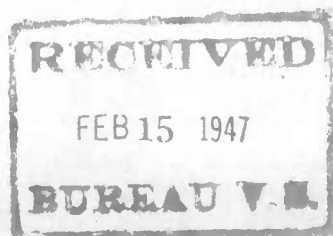
Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE J. J. Lusby M. D. or other  
 Address 2301 Potomac Date signed 13 Feb 47



1-50

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02083

302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 18 years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Wash.  
 City or town Rural Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. RFD 4  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Guy Rossman

## 3. (b) Social Security Number

214-09-4764

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Helen M. Rossman

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 4, 1879

8. AGE: Years 67 Months 9 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chambersburg, Frank. Co., Penna.  
(Town, county, and state)10. Usual occupation Dry cleaner11. Industry or business Troy Laundry Co.12. Name Hiram Augustus Grossman13. Birthplace Unknown14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Edna R. EnsmingerAddress Hagerstown, RD 4, Md.17. burial Date thereof 3-4-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Beautiful View CemeteryLocation State Line, Penna.18. Funeral director Scott F. Minnich & SonAddress Hagerstown, Md.19. Mar. 3, 47 Registrar Phyllis Bowers

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1947 at 4:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/22 to 2/28 and that I last saw him alive on 2/27

Immediate cause of death Coronary Occlusion DURATION 6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

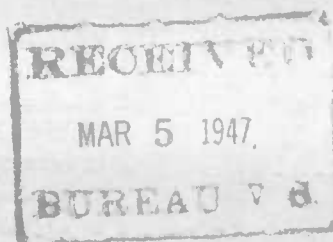
Means of injury Injured at work?

23. SIGNATURE Phyllis Bowers M.D. or otherAddress Hagerstown, Md. Date signed 3/1/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

## CERTIFICATE OF DEATH

Dr. Wells

02084

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Hours

Hospital, institution, or street address where death occurred:  
Washington County Hospital

How long in hospital or institution? 12 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Summit Ave  
 (If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

George Robert Rouskulp

## 3. (b) Social Security Number

213-16-111

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife ---

6.(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) February 3 1873

8. AGE: Years 74 Months 0 Days 9 If less than one day --- hrs. --- min.

9. Birthplace Hagerstown wash. Co. Md.  
 (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business -----

FATHER 12. Name Samuel E. Rouskulp

13. Birthplace Hagerstown Md.

MOTHER 14. Maiden name Sarah H. Brill

15. Birthplace Hagerstown Md.

16. Informant Joseph B. Reynolds

Address Hagerstown Md.

17. Burial 2/14/47

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb. 13. 47 Registrar Chas. Bowers

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1947 19 47, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 47, to 19 47

and that I last saw him alive on 19 47

Immediate cause of death chr. arteriosclerotic

Due to myocardial disease 10 yrs

Vascular hypertension 5 yrs

Due to acute ventricular

Other conditions fibrillation

(Include pregnancy within 3 months of death)

Major findings of operations no

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE A. Robert Wells M. D. or ---

Address Hagerstown, Md. Date signed 2/13/47

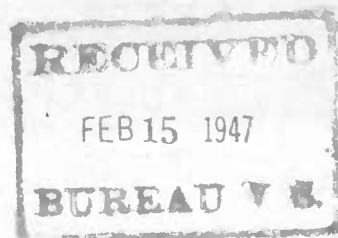
Address --- Date signed ---

Address --- Date signed ---

Address --- Date signed ---

Address --- Date signed ---

Address --- Date signed ---



1-50



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Life correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5921

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:  
1023 SPRUCE STREET

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1023 SPRUCE STREET  
 (If rural, give LOCATION)

2.(a) If veteran, name war NON-VET.

## 3. (a) FULL NAME

BERNARD UNSTOT

## 3. (b) Social Security Number

214-09-22744. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife MARGUERITE FOUKE6. (c) If alive, give age 35 years7. Birth date of deceased (mo., day, yr.) MAY, 9, 19118. AGE: Years 35 Months 9 Days 7 If less than one day hrs. min.9. Birthplace CHEWSTOWN, WASHINGTON, MD.  
(Town, county, and state)10. Usual occupation SALESMAN11. Industry or business MILK DELIVERY12. Name MARTIN RUDISILL13. Birthplace CHEWSTOWN, MD.14. Maiden name NETTIE THOMAS15. Birthplace MARYLAND16. Informant Mrs. B. C. Rudisill, wifeAddress 1023 Spruce Street17. BURIAL Date thereof 2/19/47  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory ROSE HILLLocation HAGERSTOWN, MARYLAND19. Funeral director W. A. NormentAddress Hagerstown, Md.19. Feb 17, 47 Chas. Hower  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 16, 1947 at 8:05 A.M.

21. I CERTIFY that death occurred on the date above dated; that I attended deceased from  
20 JANUARY, 1947 to 16 FEBRUARY, 1947  
 and that I last saw him alive on 13 FEBRUARY, 1947

Immediate cause of death

CARCINOMATOSIS

DURATION

Due to METASTASES FROMCARCINOMA OF SPINAL CORDDue to TV. VERTEBRAE AND ABDOM.INAL VISCERA.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. D. Layman, M.D.Address 101 PROFESSIONAL ARTS BLDG. Date signed 16 FEB 47HAGERSTOWN, MD.

RECEIVED

<sup>19</sup>  
FEB 18 1947

BUREAU

1-52

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

732

02086

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years  
 Hospital, institution, or street address where death occurred:  
 325 South Locust Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 325 South Locust Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Curtis A. Shaffer

## 3. (b) Social Security Number

214-09-9140

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Detta M. Shaffer

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 26, 1893

8. AGE: Years 54 Months 0 Days 11 If less than one day hrs. min.

9. Birthplace Sunbury, Pa.  
 (Town, county, and state)

10. Usual occupation Stone Cutter

11. Industry or business Darner Marble Works

12. Name William H. Shaffer

13. Birthplace Pennsylvania

14. Maiden name Phianna Roads

15. Birthplace Pennsylvania

16. Informant Mrs. Maud Matthews

Address Hagerstown, Maryland

17. Burial Date thereof 2-8-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smithsburg Cemetery

Location Smithsburg, Maryland

18. Funeral director C. M. Suter &amp; Sons

Address Hagerstown, Maryland

19. Feb. 6, 47 (Date rec'd by registrar) 19 47 (Date signed by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1947, at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25, 1947, to Feb. 6, 1947,

and that I last saw him alive on February 5, 1947.

Immediate cause of death Acute Congestive Heart Failure DURATION

Due to Chronic-myocarditis

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George Jennings M.D.

M. D. or other

Address 114 Broadway Hagerstown Date signed 6 Feb. 47

RECEIVED

FEB 8 1947

BUREAU V B.

1-58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

02087

246

## 1. PLACE OF DEATH:

County Washington  
 City or town Smithsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Hagerstown Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Washington  
 City or town Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Smithsburg Md #2  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Louise Lee Shifflett

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced S.

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1946  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 3 Months 17 Days 17 If less than one day  
 hrs. min.

9. Birthplace Smithsburg Md. #2  
 (Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name Leonard J. Shifflett  
 13. Birthplace Green Co., Va.

14. Maiden name Naomi Hahn  
 15. Birthplace Smithsburg Md. #2

16. Informant Leonard J. Shifflett  
 Address Smithsburg Md. #2

17. Burial Date thereof March 1, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wheatland  
 Location Waynesboro #4

18. Funeral director Walter Y. Grove  
 Address 77 S. Church St. Waynesboro Pa

19. Feb. 28, 47 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1947, at 1 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26 1947 to Feb 27 1947 and that I last saw him alive on Feb 27 1947

Immediate cause of death Bronchopneumonia 36 hrs  
 DURATION

Due to Streptococcus  
infection  
 Due to

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE G. G. H. O. H.  
 M. D. or other  
 Address Smithsburg Date signed Feb 27/47

RECEIVED  
MAR 3 1947  
BUREAU V 8.

25-1

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

Reg. Dist. No.

02088

3010

## 1. PLACE OF DEATH:

County Washington  
 City or town Williamsport  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, institution, or street address where death occurred:  
124 West Salisbury St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Williamsport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 124 West Salisbury St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Ira Milton Shipley

## 3. (b) Social Security Number

215-09-7396

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mary Elizabeth Shipley  
 6. (c) If alive, give age 61 years  
 7. Birth date of deceased (mo., day, yr.) August 31 19 days 1884 years  
 8. AGE: Years 62 Months 5 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Near Downsville, Maryland  
 (Town, county, and state) machine  
 10. Usual occupation Operated chair removing  
 11. Industry or business Byron's Tannery  
 12. Name William H. Shipley  
 13. Birthplace Downsville, Maryland  
 14. Maiden name Urella Hammond  
 15. Birthplace Downsville, Maryland

16. Informant Mrs. Mary Elizabeth Shipley  
 Address 124 West Salisbury St.: Wmsport.  
 17. Burial Burial Date thereof Feb. 10, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Greenlawn Cemetery  
 Location Williamsport, Maryland  
 18. Funeral director Mrs. Edith V. Leaf  
 Address Williamsport, Maryland

Feb 10 19 47 Mrs E Lee McElroy  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 19 47 at 3 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 19 47 to Feb 7 19 47  
 and that I last saw him alive on Feb 7 19 47  
 Immediate cause of death \_\_\_\_\_

Cerebral Occlusion. DURATION 8 days  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Pneumonia 6 weeks  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE [Signature] M. D. or other \_\_\_\_\_  
 Address [Signature] Date signed Feb. 9, 47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1-50

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

02089

30 30

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (d) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal) Which?

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

47

Joseph Murray

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19 47 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 17, 1947 to Feb. 20, 1947

and that I last saw him alive on Feb. 19, 1947

Immediate cause of death

DURATION

Premature Birth

3 days

Due to

6 1/2 mo. gestation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Clear Spring Md.

M. D. or other

Address

Date signed 2/29/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 24 1947  
BUREAU V.B.

1-50

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1602

02090

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 Days  
 Hospital, institution, or street address where death occurred:  
Washington GO Hospital  
 How long in hospital or institution? 4 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Wash.  
 City or town Smithsburg and  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. none  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war none

## 3. (a) FULL NAME

Ramond Richard Smith

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife none  
 6. (c) If alive, give age — years  
 7. Birth date 8-14-1947  
 deceased (mo., day, yr.)  
 8. AGE: Years — Months — Days 4 If less than one day — hrs. — min.

9. Birthplace Hagerstown Hospital  
 (Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name Leona Smith

13. Birthplace Bradford Pa

14. Maiden name Jeroline Ayler

15. Birthplace Bradford Pa

16. Informant Leona Smith

Address Smithsburg and

Bund

17. (Burial, cremation, or removal, Which?) Burial Date thereof 2-20-1947  
 (month) (day) (year)

Cemetery or crematory Smithsburg

Location Smithsburg and

18. Funeral director Geo B Brown

Address Smithsburg and

Feb 19 47

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/ 19 47, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/14/ 19 47 to 2/18 19 47 and that I last saw — alive on 2/17- 19 47-

Immediate cause of death Cerebral Hemorrhage

Due to —

Due to Probably due to frays

Other conditions delirium on

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Antopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Geo B Brown

M. D. or other —

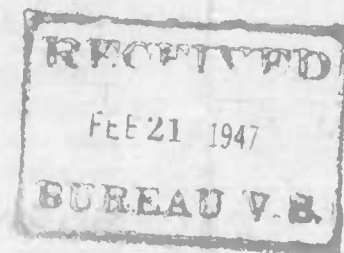
Address Hagerstown and

Date signed 2/19/47

MARGIN RESERVED FOR BINDING

VS A15 6-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-52

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22

## CERTIFICATE OF DEATH

02091 219

Reg. Dist. No. 3020

## 1. PLACE OF DEATH:

County... WASHINGTON  
 City or town... HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 2 WEEKS  
 Hospital, institution, or street address, where death occurred:  
WASHINGTON COUNTY HOSPITAL  
 How long in hospital or institution?... 8 HRS.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... PENNSYLVANIA County... FRANKLIN  
 City or town... STATE LINE  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... NON-VET. ✓

## 3. (a) FULL NAME

ISAAC N. STINE

## 3. (b) Social Security Number

NONE

4. Sex... MALE 5. Color or race... WHITE 6.(a) Single, married, widowed, or divorced... SINGLE

## 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)... FEBRUARY 14, 1873 6.(c) If alive, give age... years

8. AGE: Years... 73 Months... 11 Days... 27 It less than one day... hrs. ... min.

9. Birthplace... STATE LINE, FRANKLIN, PA.  
 (Town, county, and state)

10. Usual occupation... RETIRED CARPENTER

## 11. Industry or business

12. Name... ABRAHAM STINE  
 13. Birthplace... STATE LINE, PA.  
 14. Maiden name... CAROLINE HOOVER  
 15. Birthplace... MARYLAND

16. Informant... Ruth Stine  
 Address... Chambersburg, Pa.

17. BURIAL Date thereof... Feb 13, 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... BEAUTIFUL VIEW  
 Location... WASHINGTON COUNTY MD

18. Funeral director... W. J. Normant  
 Address... Hagerstown, Md.

19. Feb. 16, 1947 Registrar... Chas. H. Bowers  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb. 10, 1947, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10, 1947, to Feb. 10, 1947,  
 and that I last saw him alive on Feb. 10, 1947.

Immediate cause of death... Chronic Myocarditis DURATION... ?

Due to...  
 Due to...

Other conditions... Acute Alcoholism  
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ...

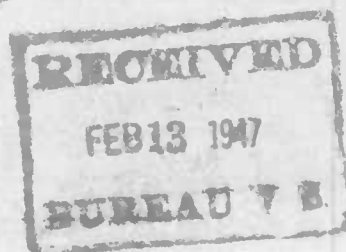
Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of ...  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... Dr. Beasley M.D.  
Hagerstown, Md. Date signed... Feb. 10/47  
 Address... Date signed...

221 W. Wash



1-50



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 835

## CERTIFICATE OF DEATH

02092  
3020  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years  
Hospital, institution, or street address where death occurred:  
118 South Prospect Street

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 118 South Prospect Street  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Mahlon S. Taylor

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Frances P. Taylor6.(c) If alive, give age 31 years7. Birth date of deceased (mo., day, yr.) August 26, 19088. AGE: Years 38 Months 5 Days 20 If less than one day  
.....hrs. ....min.9. Birthplace Lincoln, Virginia  
(Town, county, and state)10. Usual occupation Tool Planner11. Industry or business Fairchild Corp.12. Name Lawrence H. Taylor13. Birthplace Lincoln, Virginia14. Maiden name Mabel A. Robert15. Birthplace Creighton, Neb.16. Informant Mrs. Mahlon S. TaylorAddress Hagerstown, Maryland17. Burial Date thereof 2-18-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lincoln CemeteryLocation Lincoln, Virginia18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland19. Feb. 16, 1947 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Feb 19 47 at 1:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Feb 19 47 to 16 Feb 19 47 and that I last saw him alive on 16 Feb 19 47Immediate cause of death Cerebral Hemorrhage DURATION 1 day

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J J Lusky M. D. or otherAddress 230 N Potomac Date signed 16 Feb 47

MARGIN RESERVED FOR BINDING

VS A15

9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 18 1947  
BUREAU V.S.

1-58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-P)

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH: Washington  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 60 years  
 Hospital, institution, or street address where death occurred:  
 Washington County Hospital  
 How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 Maryland Washington  
 State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 639 N. Locust St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Ida Bell Trite

## 3. (b) Social Security Number

4. Sex Female  
 5. Color or race White  
 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Edward Trite  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) July 5, 1885  
 8. AGE: Years 61 Months 7 Days 12  
 If less than one day..... hrs. .... min.

9. Birthplace Mariansville Mo.  
 (Town, county, and state)  
 10. Usual occupation None  
 11. Industry or business None  
 12. Name Aquella Ward  
 13. Birthplace Mariansville Mo.  
 14. Maiden name Baraba ann Smith  
 15. Birthplace Mariansville Mo.

18. Informant Frank E. Trite  
 Address Funkstown Md.

17. Burial Date thereof 2-20-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.  
 18. Funeral director Scott F. Minnich & Son  
 Address Hagerstown Md.

19. Feb. 19. 47 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1947 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Feb. 15 47 to Feb. 17 47 and that I last saw him alive on Feb. 17 47.

Immediate cause of death Cerebral Thrombosis. DURATION

Due to.....

Due to.....

Other conditions Anterior Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

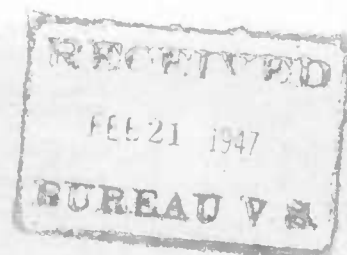
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Dr. B. Beach M. D. or other

Address Hagerstown Md. Date signed Feb. 18/47



1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

## CERTIFICATE OF DEATH

Reg. Dist. No. 02094 3060

## 1. PLACE OF DEATH:

County WashingtonCity or town Cascade Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WashingtonCity or town Cascade  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Edward James Wade Jr.

## 3. (b) Social Security Number

## 4. Sex

M.

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

W.

## 6. (b) Name of husband or wife

Annie M. Wade

## 6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

June 27, 1867

## 8. AGE:

Years

Months

Days

If less than one day

79719

hrs.

min.

## 9. Birthplace

Cascade Md.  
(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

## FATHER

## 12. Name

Edward J. Wade Sr.

## 13. Birthplace

Ireland

## MOTHER

## 14. Maiden name

Susan Myers

## 15. Birthplace

Middleburg Md.

## 16. Informant

Harry A. Wade

## Address

Cascade Md.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

2/18/47  
(month) (day) (year)

## Cemetery or crematory

Bethel C.

## Location

Md.

## 18. Funeral director

Walter Y. Grove

## Address

Wagonsburg Pa.

## 19.

(Date rec'd by registrar)

19

Geo. W. Ferguson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1947 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that it attended deceased from

1-15 1947 to 2-16 1947and that I last saw him alive on 2-16 1947

Immediate cause of death

DURATION

Acute ArteriosclerosisDue to Chronic ArteriosclerosisDue to HypertensionOther conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

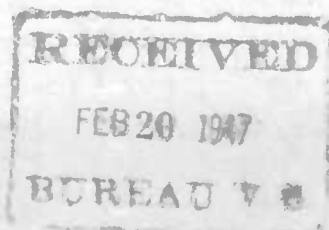
Means of injury

Injured at work?

## 23. SIGNATURE

M. D. or other

W. C. Bridgman  
Blue Ridge Summit Pa  
Date signed 2/17/47



1-50

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

Reg. Dist. No.

02095  
3071

### 1. PLACE OF DEATH:

County... Washington  
City or town... Brownsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
Main St.  
How long in hospital or institution? at home

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
City or town... Brownsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Main St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war no.

### 3. (a) FULL NAME

Annie Matilda Younkies

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Morse A. Younkies  
7. Birth date of deceased (mo., day, yr.) October, 23 - 1880 6. (c) If alive, give age... years  
8. AGE: Years 66 Months 3 Days 12 If less than one day... hrs. ... min.

9. Birthplace Brownsville Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business Own Home

12. Name George W. Touch

13. Birthplace Brownsville Wash. Co. Md.

14. Maiden name Abigail Jennings

15. Birthplace Brownsville Wash. Co. Md.

16. Informant Morse A. Younkies

Address Brownsville Md.

17. Burial Date thereof February 7 - 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Church of the Brethren Cemetery

Location Brownsville Md.

18. Funeral director Wm. J. Bast & Sons

Address Brownsville Md.

19. Feb 7 19 47 Cornelius H. Baatle  
(Date rec'd by registrar) (year) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 19 47 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 45 to Feb. 5 19 47  
and that I last saw him alive on Feb. 5 19 47

Immediate cause of death Cerebral Hemorrhage DURATION 2 days

Due to hypertension and arteriosclerosis 4 yrs. +

Due to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Walter H. Spealy M.D. M. D. or other

Address Springburg, Md. Date signed 2/7/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Spealy



RECEIVED  
FEB 13 1947  
BUREAU

2-40

2-3078 11-11-47 2-10